New Patient Health Questionnaire

Please arrive 30 minutes prior to your new patient appointment

Last Name:	First Name:	DOB:	☐ F ☐ M ☐ _____
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			Email Address:
Previous Primary Care Provider:			Date of last physical exam:

Medications (use back of page if needed): **Please bring all prescription medications you are currently taking**		
Name	Dose and Directions	Reason

Allergies and Reactions: _____

Do you currently have, or have ever had, any of the following illnesses or conditions?

☐ Abnormal Pap	☐ Gallbladder Disease	☐ Osteoporosis
☐ Alcohol/Drug Problem	☐ Glaucoma	☐ Other Injuries
☐ Anemia	☐ Gout	☐ Peripheral Artery Disease
☐ Anxiety/Depression	☐ Hay Fever	☐ Pneumonia
☐ Arthritis	☐ Head Injury	☐ Positive TB Test
☐ Asthma	☐ Heart Attack	☐ Prostate Problem
☐ Atrial Fibrillation	☐ Heart Disease	☐ Psychiatric-Depression
☐ Blood Clots	☐ Heart murmur	☐ Psychiatric-Other
☐ Cancer	☐ Hepatitis/Liver Disease	☐ Rheumatic Fever
☐ Chicken Pox	☐ Hernia	☐ Seizures
☐ Chronic Lung Disease	☐ High Blood Pressure	☐ Sexually Transmitted Disease
☐ Colon/Bowel Disease	☐ High Cholesterol	☐ Sleep Apnea
☐ Dementia	☐ Infection of the uterus	☐ Stroke
☐ Diabetes Type I or II	☐ Kidney Disease	☐ Thyroid Disease
☐ Diverticulitis	☐ Migraines	☐ Tuberculosis
☐ Emphysema	☐ Neuropathy	☐ Ulcer

Surgical and Hospitalization History (include dates)	

Family History *(Use back of page if needed)*			**Age**	**Medical conditions** Indicate **Healthy** -or- diabetes, high blood pressure, cholesterol, heart disease, stroke, cancer (type)
Mother		□ Living □ Deceased		
Father		□ Living □ Deceased		
Sibling	□ F □ M	□ Living □ Deceased		
Sibling	□ F □ M	□ Living □ Deceased		
Sibling	□ F □ M	□ Living □ Deceased		
Sibling	□ F □ M	□ Living □ Deceased		
Grandmother Mother's Side		□ Living □ Deceased		
Grandfather Mother's Side		□ Living □ Deceased		
Grandmother Father's Side		□ Living □ Deceased		
Grandfather Father's Side		□ Living □ Deceased		
Children	□ F □ M	□ Living □ Deceased		
Children	□ F □ M	□ Living □ Deceased		
Extended Family Members			□ Cancer	□ Heart attacks □ Stroke □ Diabetes

Patient History					
Smoking	**Cigarette Use:**	☐ Never ☐ Former Smoker ☐ Current Smoker	Date quit or age:		
	Other tobacco use:	☐ Pipe	☐ Cigars	☐ Chewing Tobacco	
	Other:	☐ e-Cigarettes	☐ Marijuana		
Alcohol	**Do you drink alcohol?**	☐ Yes ☐ 0-1 times/month ☐ 2-4 times/month ☐ Every week ☐ No			
	Each week, how many: _____ Servings of beer? _____ Glasses of wine? _____ Shots/mixed drinks? _____				
	When did you last have more than 4 drinks in one day? _____				
	Do you feel you should cut down on your drinking?			☐ Yes	☐ No
	Do people annoy you by nagging about your drinking?			☐ Yes	☐ No
	Have you ever felt guilty about drinking?			☐ Yes	☐ No
	Have you ever had a morning drink to steady your nerves?			☐ Yes	☐ No
Drugs	Have you used recreational or street drugs within the last two years?			☐ Yes	☐ No
	Have you ever used recreational drugs with a needle?			☐ Yes	☐ No
Sexual Health	☐ Sexually active ☐ Not currently sexually active ☐ Never sexually active				
	Sexual Partners: ☐ Men ☐ Women # of Partners in last year:				
	History of Sexually Transmitted infections? If yes, type/dates:				
	Current contraception method: Previous methods:				
	Women: # of children:_____ # of pregnancies:_____ # of miscarriages:_____ # of abortions:_____ Date of last menstrual period:				

Personal Safety	Do you wear a seatbelt?	☐	Yes	☐	No
	Have you fallen in the last year?	☐	Yes	☐	No
	If yes, how many times?_____ Any injuries?_____				
	Do you feel unsteady when standing or walking?	☐	Yes	☐	No
	Do you worry about falling?	☐	Yes	☐	No
	Does your house have a working smoke detector?	☐	Yes	☐	No
	Does a partner, or anyone at home, hurt, hit, or threaten you, or take advantage of you financially?	☐	Yes	☐	No
Patient Health	**Over the last two weeks, how often have you been bothered by any of the following problems?** **Little interest or pleasure in doing things** □ Not at all □ Several Days □ More than Half of the Days □ Nearly Every Day **Feeling down, depressed, or hopeless** □ Not at all □ Several Days □ More than Half of the Days □ Nearly Every Day				
Exercise	☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk three blocks, golf) ☐ Occasional vigorous exercise (i.e., work or recreation 1-3x week for 30 minutes) ☐ Regular vigorous exercise (i.e., work or recreation > 3x/week for 30 minutes)				

Immunizations (use back of page if needed)	**Date**	**Immunization**	**Date**
□ Flu Vaccine		□ TD (Tetanus Shot)	
□ TDAP (Whooping Cough/Tetanus)		□ Zostavax (Shingles) □ Shingrix (Shingles)	
□ Pneumococcal PCV13		□ HPV	
□ Pneumococcal PPV23		□ Meningococcal ACWY	
□ Hepatitis A		□ Meningococcal B	
□ Hepatitis B		□ Other:	

Please list the names of the physicians and specialists you have seen (use back of page if needed)**:**			
Previous Primary Care		Gynecologist	
Gastroenterologist (GI)		Urologist	
Cardiologist		Eye doctor	
Other		Other	

Preventative Screenings: To avoid duplication and to provide you with the best care possible, we would like the information on the following items and to obtain a copy of your most recent reports. **Either bring a us a copy** or **let us know from where we can request a copy**. (Not all ages and genders will need to provide the information listed below.)

Item	**Date last performed**	**Result (if applicable)**	**Comments**
Aortic Aneurysm Screen			
Bone Density Test			
Cholesterol Test			
Colonoscopy			
Dental Exam			
Eye Exam			
Hepatitis C Test			
HIV Test			
HPV Test			
Mammogram			
Pap Smear			
Prostate Exam			
Stool Test for Blood			

Additional Comments: (use back of page if needed)