RAVENCREST MEDICAL

NEW PATIENT QUESTIONNAIRE

Today's Date: ___/___/_____ Reason for visit:_____

PERSONAL INFORMATION

Legal Name (First Middle Last): _____
Date of Birth:____/___/_____ Sex: __Male __Female SSN#:_____-_____-_____
Age:____ Nickname:_____
Primary Language:_____ Secondary Language:_____
Do you have any special needs in the following areas?
☐ Reading ☐ Hearing ☐ Vision ☐ Mobility (eg. Wheelchair, walker) ☐ Communication (eg. Need a translator)

HOME

☐ Single ☐ Married ☐ Civil Union ☐ Divorced ☐ Widowed
List children with ages:_____
_____

EMPLOYMENT

☐ Full-Time ☐ Part-Time ☐ Homemaker ☐ Looking ☐ Disabled ☐ Retired ☐ Student
List Occupation: _____
List Former Occupation if Retired:_____

ALLERGIES

List allergies and type of reaction you had.

Allergy:_____	Reaction:_____
Allergy:_____	Reaction:_____
Allergy:_____	Reaction:_____
Allergy:_____	Reaction:_____

Patient Name:_____ DOB:_____

MEDICATIONS

List All Medications and Supplements (Please remember to bring these to your appointment)

1.)_____ 6.) _____
2.)_____ 7.) _____
3.) _____ 8.) _____
4.) _____ 9.) _____
5.) _____ 10.) _____

MEDICAL CONDITIONS (CHECK ALL THAT APPLY)

__Allergies
__Anemia
__Anxiety
__Arthritis
__Asthma
__Blood transfusion
__Cancer
__Clotting disorder
__Congestive heart failure
__Depression
__Diabetes mellitus
__Emphysema/COPD
__Gastroesophageal reflux disease (GERD)
__Glaucoma
__Heart murmur
__HIV/AIDS
__High cholesterol
__Hypertension
__Kidney disease
__Myocardial infarction
__Nerve/muscle disease
__Osteoporosis
__Seizures
__Sickle cell anemia
__Substance abuse
__Thyroid disease
__Tuberculosis

Details/Other:_____

SURGICAL HISTORY (CHECK ALL THAT APPLY)

__Appendectomy
__Bladder surgery
__Brain surgery
__Breast surgery
__Bunionectomy
__CABG
__Cardiac stent
__Cholecystectomy
__Colon surgery
__C-section
__Lung surgery
__Eye surgery
__Fracture surgery
__Hernia repair
__Hysterectomy
__Joint surgery
__Prostate surgery
__Small intestine surgery
__Spine surgery
__Thyroid surgery
__Tonsillectomy
__Tubal ligation
__Valve replacement
__Varicose vein surgery
__Vasectomy
__Vascular surgery
__Weight reduction surgery

Details/Other:_____

Have you ever had a blood transfusion?:_____If YES, approx. Date:_____

Patient Name:_____DOB:_____

FAMILY HISTORY (CHECK ALL THAT APPLY)

	Alcohol/Drug Abuse	Breast Cancer	Ovarian Cancer	Lung Cancer	Prostate Cancer	Diabetes	Heart Disease	High Cholesterol	Mental Illness
Mother									
Father									
Son									
Daughter									
Sibling									
Other Family									

Other Family History:_____

SEXUAL HISTORY

My sexual partners have been:
☐ Male ☐ Female ☐ Both ☐ I've never been sexually active
Have you had more than one sexual partner in the last year? ___No ___Yes.
If yes, how many:_____
Have you ever had a sexually transmitted disease? ___No ___Yes
If Yes, then what and when?_____
Do you use condoms? __No __Yes

GYNECOLOGICAL HISTORY

How many times have you been pregnant ?___ Miscarriages?___ Live births?___ Still Births?___ Abortions?___
Age at First Menarche:_____
Age at Menopause:_____ Are you experiencing symptoms? (describe):
_____
If you are still menstruating describe your menstrual cycle ____Regular____Irregular
PMS or other menstrual complications?_____
Any gynecological conditions?_____
Do you use a form of birth control? __No __Yes. If Yes, then what:_____
Are you trying to become pregnant?___No___Yes
Who is your OB/GYN provider, if you have one?_____

Patient Name:_____ DOB:_____

SOCIAL HISTORY

Do you use tobacco? __ No ___Yes ___Cigarettes ___Cigars ___Chewing tobacco ____Vape
If you smoke cigarettes, then how many packs/day_____ For how many years?_____
If you vape, then describe how much:_____
Do you use Marijuana?__ No __Yes. If Yes, then how often? ____Daily____Weekly____Monthly
Do you use other marijuana containing products? Describe:_____
Any history of illicit drug use?___No___Yes. If Yes, then what?_____
Any IV drug use specifically?_____
How often do you consume alcoholic beverage? __Never__Daily__Weekly__Monthly__Yearly
How much alcohol to you consume at one time, approximately?_____
_____
Do you adhere to a diet?__No__Yes. If Yes, then what diet?_____
Do you exercise?__No__Yes. If Yes, then for how long and how many times per week?_____
_____

IMMUNIZATIONS

Are you up to date on recommended vaccinations? ___No___Yes
How you ever had vaccine reaction?___No___Yes. If Yes, then please describe reaction and when it occurred:_____

PREVENTATIVE HEALTH (GIVE APPROXIMATE DATES)

Last PAP Smear:_____ Never___
Last STD Test:_____ Never___
Last Mammogram:_____ Never___
Last Dexa Scan:_____ Never___
Last Colonoscopy:_____ Never___
Last ECG/EKG:_____ Never___
Last Lung Cancer Screen:_____ Never___
Last Diabetes Screen:_____ Never___
Last Cholesterol Screen:_____ Never___
Last Prostate Cancer Screen:_____ Never___

OTHER HEALTH HISTORY

Do you feel safe at home?__No__Yes
In the last year, Have you had any major life stresses? (eg. Death in family, Employment, Illness?):_____
_____
Any other concerns you'd like your provider to know?_____

Today's Date:____/_____/_____

Patient Signature:_____
Parent/Guardian Signature:_____