NEW PATIENT QUESTIONNAIRE

Today's Date: _____ NAME: _____ Date of Birth: _____

What are your health goals for the next year?

_____

_____

What are your top two health concerns you'd like to address today?

1. _____ 2. _____

Previous Primary Care Provider (Name, City, Phone#):

_____

PERSONAL SURGICAL HISTORY

Surgical Procedure	*Year*	*Surgeon/Hospital*

Please list ALL healthcare providers you see regularly or have seen in the last 5 years:

Ex. Cardiology, Pulmonologist, Nephrologist (Kidney), Urologist, Orthopedist, Rheumatologist, Physical Therapist, Podiatrist, Chiropractor, Acupuncturist, Massage Therapist, Nutritionist, Naturopath, Dentist, Optometrist/Ophthalmologist, Neurologist, Gynecologist, Psychiatrist, Psychologist, Counselor, Oncologist.

Name	Facility/Clinic & City	Phone #	Specialty

ALLERGIES – Please list all allergies to medications and foods.

Medication or Food	Reaction	Last Happened?

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PERSONAL MEDICAL & HEALTH HISTORY					
Condition	***Now***	***Past***	***Condition***	***Now***	***Past***
Alcohol / Drug Addiction			Gallbladder Disease		
Allergies (Hay Fever)			GERD / reflux / heartburn		
Anemia			Glaucoma		
Anxiety			Gout		
Arthritis (Rheumatoid)			Heart Attack		
Arthritis (Osteoarthritis)			Hepatitis		
Asthma			Hypertension (blood pressure)		
AutoImmune Disease			High Cholesterol		
Bladder Problems			Irritable Bowel Syndrome		
Bleeding/Clotting Disorder			Kidney Disease/Failure		
Blood Clot (leg)			Kidney Stones		
Blood Clot (lung)			Kidney Disease - other		
Blood Transfusion			Liver Disease		
Breast Lump (benign)			Migraine Headaches		
Cancer Breast			Osteopenia/Osteoporosis		
Cancer Colon			Psoriasis		
Cancer Other Type			Pulmonary Embolism (lung clot)		
Cancer Ovarian			Prostate Problems		
Cancer Prostate			Seizures		
Cataracts			Sleep Apnea		
Colon Polyp			Stroke / TIA		
COPD (emphysema)			Thyroid Overactive (hyper)		
Coronary Artery Disease			Thyroid Underactive (hypo)		
Depression			Thyroid problems - other		
Diabetes			Ulcer		
Diverticulosis/Diverticulitis			Fractures (Broken Bones):		
Eczema (Dermatitis)			Other:		
Endometriosis			Other:		
Fibroids			Other:		

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FAMILY MEDICAL HISTORY

	Mother	Father	Sister (s)	Brother (s)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other blood relatives (List relation)		
Alive											
Deceased											
Age currently or at death											
Diseases & Conditions										***Age at Diagnosis***	***cause of death?***
Alcohol / Drug Addiction											Y N
Alzheimer's or Dementia											Y N
Anxiety or Depression											Y N
AutoImmune Disease											Y N
Asthma											Y N
Bleeding/Clotting Disorder											Y N
Cancer Breast											Y N
Cancer Colon											Y N
Cancer Other Type											Y N
Cancer Ovarian											Y N
Cancer Prostate											Y N
COPD (emphysema)											Y N
Diabetes											Y N
Genetic Disorder											Y N
Heart Attack											Y N
Heart Disease											Y N
Hepatitis											Y N
Kidney Disease											Y N
Kidney Stones											Y N
Liver Disease											Y N
Stroke											Y N
Thyroid Disease											Y N
Other:											Y N

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VACCINES – Enter year (if known) of vaccinations you have had.

Tetanus (Td) _____ with Pertussis (TdaP) _____ Influenza (Flu) _____

COVID _____ circle brand: *Moderna* *Pfizer* *J&J/Janssen*

Pneumococcal (PPSV23) _____Pneumococcal (PCV13)_____

Shingles: Zostavax (newer 1-dose) _____ Shingrix (older 2-dose) _____

Hepatitis A _____ Hepatitis B _____ HPV _____

Varicella (Chickenpox) _____

Other _____

PERSONAL TESTING HISTORY

Test	***Year***	***Surgeon/Hospital***	***Results***
Angiogram			
Biopsy			
Cardiac Stress Test			
Colonoscopy			
DEXA (bone density)			
ECG/EKG			
Echocardiogram			
EGD (stomach endoscopy)			
ERCP/MRCP			
Sleep Study			
Pulmonary Function Test			
CT			
MRI			
Other:			

Please list **ALL MEDICAL DEVICES** you use regularly or on an as needed basis.
Ex. Wheelchair, walker, cane, prosthesis, CPAP, oxygen, TENS machine

Device	Details	Why?

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MEDICATIONS – Please complete or attach a medication list

Please list ALL **PRESCRIPTION MEDICATION** that you take or use regularly or on an as needed basis.

Medication	Dose	How many times per day?	Why?

Please list ALL **OVER THE COUNTER MEDICATION** that you take regularly or on an as needed basis.

Medication	Dose	How many times per day?	Why?

Please list ALL **VITAMINS, MINERALS AND SUPPLEMENTS** that you take regularly or on an as needed basis.

Vitamin, Mineral, Supplement	Dose	How many times per day?	Why?

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PERSONAL/SOCIAL HISTORY

Who do you live with? _____

Marital Status: Single Married Divorced Widow/Widower

Spouse's Name: _____

How many children do you have? _____ Do any live nearby? Y N

Do you have any pets? **Y** N Details: _____

What are your hobbies, what do you do in your spare time? _____

_____

Circle the type of diet you follow: Regular Vegetarian Vegan Gluten Free Mediterranean Keto

Other: _____

How many fruits and vegetables do you eat daily? _____

How many days per week do you do moderate exercise, like gardening or going for a brisk walk?

_____

What type of exercise do you do and how often? _____

How many hours of sleep do you get every night? _____

Do you drink alcohol? **Y** N

What type & how much/often? (ex.1 glass wine nightly, 6pack beer every Saturday): _____

Do you use tobacco? **Y** N

What type (smoking, vaping, chewing, snuff) and how much/often? (ex. 1/2 pack per day, tin of chew weekly):_____

_____

Do you use marijuana products (CBD or THC, topical, edible, vape, smoke, pills)? **Y** N

What type and how much/often? _____

_____

Do you ingest caffeine daily? **Y** N

If so, how much and of what? _____

Do you take opiates (vicodin, hydrocodone, tramadol, codeine, fentanyl, oxycodone, heroin)? **Y** N

Do you take any stimulants (Adderall, Ritalin, Methamphetamine)? **Y** N

Do you take any sedatives like barbiturates, benzodiazepines or hypnotics (sleep medications)? **Y** N

Do you use any recreational drugs? **Y** N

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WOMEN ONLY

Age at menarche (first period ever)? _____

Age at menopause (last period ever)? _____

If you have gone through menopause, have you had any bleeding since? **Y** N

First Day of Last Menstrual Period: _____

Periods come every _____ days and usually last _____ days

Do you experience heavy bleeding or clotting during your period? **Y** N

Do you experience severe cramping during your period? **Y** N

Have you had a hysterectomy? **Y** N

# of pregnancies: _____ # children born alive: _____

# of miscarriages: _____ # of abortions: _____

# of cesareans: _____

Were there any complications with any of your pregnancies? **Y** N

Please explain: _____

Are you sexually active? **Y** N With men, women or both? _____

Number of sexual partners in last year:_____

Do you ever have sex without a condom? **Y** N

Current Birth Control Method:_____

Are you interested in changing or starting birth control? **Y** N

Have you ever had a sexually transmitted infection? **Y** N

Are you worried you might currently have a sexually transmitted infection? **Y** N

Do you feel safe in your relationship? Y **N**

Does your partner ever hit you, threaten you or force you to have sex? **Y** N

Does your partner(s) use IV drugs? **Y** N

Last pap: _____ Results: Normal **Abnormal** **Don't know**

Have you ever had an abnormal pap? **Y** N

Please explain: _____

Do you have any vaginal complaints? **Y** N

Please explain: (pain, itching, swelling, discharge, etc…): _____

_____

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Last Mammogram: _____ Results: Normal **Abnormal** **Don't know**

Have you ever had an abnormal mammogram? **Y** N

Please explain: _____

Do you have any breast complaints? **Y** N

Please explain: (pain, lumps, rashes, nipple changes, etc…): _____ _____

_____

Last Bone Density Exam (DEXA): _____

Results: Normal **Osteopenia** **Osteoperosis** **Don't Know**

Do you take Vitamin D? Y N What dose & how often?_____

Do you take Calcium? Y N What dose & how often?_____ _____

Do you take any other medicine for bone health/strength? Y N

What, how much, & how often?_____

Have you ever broke a bone? Y N

Please explain: _____

_____

_____

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MEN ONLY

Are you sexually active? **Y** N With men, women or both? _____

Number of sexual partners in last year:_____

Do you ever have sex without a condom? **Y** N

Have you ever had a sexually transmitted infection? **Y** N

Are you worried you might currently have a sexually transmitted infection? **Y** N

Do you feel safe in your relationship? Y **N**

Does your partner ever hit you, threaten you or force you to have sex? **Y** N

Does your partner(s) use IV drugs? **Y** N

Have you ever had problems with your prostate? **Y** N

How strong is your urine stream? Strong **Okay** **Weak** **Varies**

Do you ever dribble urine or are you ever incontinent? **Y** N

Do you ever have pain when urinating? **Y** N

Do you ever see blood in your urine? **Y** N

Do you ever have trouble getting an erection? **Y** N

Do you ever have any problems with ejaculation (difficulty, pain, blood)? **Y** N

Have you ever had an elevated PSA (prostate specific antigen blood test)? **Y** N

IF OVER 65

Last Bone Density Exam (DEXA): _____

Results: Normal **Osteopenia** **Osteoperosis** **Don't Know**

Do you take Vitamin D? Y N What dose & how often?_____

Do you take Calcium? Y N What dose & how often?_____

Have you ever broke a bone? **Y** N

Please explain: _____

_____

_____

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