INFECTIOUS DISEASE NEW PATIENT HEALTH QUESTIONAIRE

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Location: _____

Who referred you to our office? _____ Phone: _____

Reason you here today are: _____

Other Health Care Providers you have seen for the same thing? _____

Primary Care Physician: _____Phone: _____Date of last Visit: _____

MEDICATIONS

Please list all prescription and non-prescription medicines, vitamins, home remedies, birth control, and herbs.

MEDICATION	DOSE	HOW MANY TIMES PER DAY	HOW LONG HAVE YOU TAKEN

ALLERGIES

MEDICATION	REACTION	AGE AT WHICH THIS OCCURRED

Please list any food, tape, and latex or other non-medication allergies.

_____

_____

SOCIAL HISTORY

Occupation: _____ Employer: _____

How long have you done this type of work? _____ Previous line of work: _____

Years of Education/Degree: _____ Where did you attend school? _____

Spouse/Partner Name: _____ Number of Children/Ages: _____

Does anyone live at home with you? If so who: _____

Hobbies: _____ Pets: _____

Do you have any culinary habits? (raw fish, raw steak) _____

IMMUNIZATION/TRAVEL HISTORY

Have you ever had any of the following immunizations? If so when?

Hepatitis A: _____ Hepatitis B:_____ Influenza (flu):_____Measles:_____
Rubella:_____ Tetanus (Td):_____Pneumonia (pneumovax):_____
Varicella (chicken pox):_____ or Illness: _____
PPD (Tuberculosis skin test):_____ Have you ever tested positive?_____
If yes, when were you treated?_____ How long were you treated?_____
How long have you lived I Nebraska? _____
Previous Cities and States: _____
Have you traveled outside the United States? If so where and when did you travel? _____
_____

RISK ASSESSMENT

Tobacco Use: ☐ Never ☐ Quit, When _____ How long? _____ ☐ Cigarette packs per day _____ How long? ____

☐ Pipe ☐ Chewing Tobacco Are you interested in information about quitting? _____

Alcohol Use: Do you drink alcohol? ☐ Yes ☐ No Number of drinks per week: _____

Is your alcohol use a concern to you or others? ☐ Yes ☐ No Are you interested in trying to quit? _____

Drug Use: Do you use recreational drugs? ☐ Yes ☐ No If yes, how long have you been using? _____

☐ Marijuana ☐ Cocaine ☐ Methamphetamines, Do you share needles? ☐ Yes ☐ No, Are you interested in quitting?_____

Advance Directives: Do you have a Living Will or Durable Power of Attorney? ☐ Yes ☐ No

Sexual Activity: Are you sexually active? ☐ No ☐ Yes ☐ Not Currently

Current sex partner(s) is/are: ☐ Male ☐ Female ☐ Both Do you have multiple partners? ☐ Yes ☐ No

Do you practice safe sex? _____ If yes, what methods do you use? _____

Have you ever had sexually transmitted diseases? If so, when? _____ ☐ Gonorrhea ☐ Syphilis ☐ Chlamydia

Have you ever been tested for HIV? _____ If so when was last test? _____ Was it positive or negative? _____

PAST MEDICAL HISTORY

Please list all major hospitalizations or surgeries

YEAR	OPERATION OR ILLNESS	HOSPITAL

Do you have problems with any of the following? Circle: Yes or No

Y	N	Change in appetite	Y	N	Wheezing
Y	N	Chills	Y	N	Chest Pain
Y	N	Fatigue	Y	N	Difficulty lying flat
Y	N	Fever	Y	N	High Blood Pressure
Y	N	Headache	Y	N	Irregular Heart rate or palpitations
Y	N	Lightheadedness	Y	N	Abdominal Pain
Y	N	Night Sweats	Y	N	Constipation
Y	N	Sleep Disturbance	Y	N	Diarrhea
Y	N	Weight gain	Y	N	Hepatitis
Y	N	Weight loss	Y	N	Heartburn
Y	N	Allergic rhinitis	Y	N	Nausea and vomiting
Y	N	Vision Changes	Y	N	Black or bloody stools
Y	N	Decreasing hearing	Y	N	Easy bruising and prolonged bleeding
Y	N	Ringing in ears	Y	N	Cancer
Y	N	Sinus pain	Y	N	Painful urination
Y	N	Sore throat	Y	N	Muscle aches
Y	N	Swollen glands	Y	N	Joint pain
Y	N	Diabetes	Y	N	Peripheral vascular disease
Y	N	Thyroid disease	Y	N	Rash
Y	N	Frequent urination	Y	N	Itching
Y	N	Excessive thirst	Y	N	History of stroke
Y	N	COPD	Y	N	Seizure disorder
Y	N	Asthma	Y	N	Tingling/numbness
Y	N	Cough	Y	N	Pain
Y	N	Shortness of breath at rest	Y	N	Memory loss
Y	N	Shortness of breath with activity	Y	N	Anxiety
Y	N	Sputum production	Y	N	Depressed mood

Women:

Number of pregnancies? _____ Number of births? _____

Y	N	Frequent urinary tract infections
Y	N	Genital herpes
Y	N	Irregular periods
Y	N	Painful menstruation
Y	N	Vaginal discharge

Men:

Y	N	Lumps or infection of testicles
Y	N	Penile discharge
Y	N	Premature ejaculation
Y	N	Enlarged prostate
Y	N	Trouble achieving or maintaining erection
Y	N	Genital herpes

FAMILY HISTORY

Have any of your relatives had any of the following? Who?

Y	N	Diabetes _____
Y	N	High Blood pressure_____
Y	N	Heart Disease _____
Y	N	Stroke _____
Y	N	Mental Illness _____
Y	N	Cancer _____
Y	N	Other _____

Please list age and state of health of family. (Good, Fair, Poor) Date of death & reason

Mother_____

Father _____

Brothers _____

Sisters _____

Children _____