NEW PATIENT QUESTIONNAIRE

Name:_____ **Date of birth:**_____ **Date completed:**_____

Previous Primary Care Physician: _____

Date of last physical exam: _____

Other health care providers, such as specialists:

Specialty	Name	Phone	Date last seen

PERSONAL HEALTH HISTORY

Medications, include over-the-counter medications, vitamins and supplements:

Drug name	Dose and directions	Reason

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Allergies and reactions, include food and environmental: ☐ I have no known allergies

Name	Reaction / Comments

Immunizations, include approximate year or age, if known:

☐ Tetanus
☐ Pneumonia (Prevnar)
☐ Pneumonia (Pneumovax)
☐ Varicella (Chicken Pox)
☐ Shingles (Zostavax)
☐ Shingles (Shingrix)
☐ Gardasil
☐ Influenza
☐ Hepatitis A
☐ Hepatitis B
☐ PPD, mark + if ever positive
☐ TB (Tuberculosis shot)

Other: _____

Screening tests:

Test	Where	Year	Normal	Explain
Cholesterol			☐ Yes ☐ No	
Colonoscopy			☐ Yes ☐ No	
Mammogram			☐ Yes ☐ No	
Bone density			☐ Yes ☐ No	
Pap smear			☐ Yes ☐ No	
PSA (Prostate cancer test)			☐ Yes ☐ No	
Prostate check			☐ Yes ☐ No	
Diabetes test			☐ Yes ☐ No	
Eye exam			☐ Yes ☐ No	
Dental exam			☐ Yes ☐ No	
HIV test			☐ Yes ☐ No	

Name:_____ **Date of birth:**_____ **Date completed:**_____

Medical History

(Check if you ever have been diagnosed, or had the following conditions. Mark year of the diagnosis, if known.)

- ☐ Allergies
- ☐ Alcohol / drug problem
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis (Rheumatoid)
- ☐ Arthritis (Osteo)
- ☐ Asthma
- ☐ A-fib, details _____
- ☐ Blood Transfusion
- ☐ Bipolar
- ☐ Cancer, details _____
- ☐ Chest Pain (Angina)
- ☐ Chronic Lung Disease
- ☐ Clotting Disorder
- ☐ Colon Polyps
- ☐ Congestive Heart Failure
- ☐ Constipation
- ☐ COPD
- ☐ Coronary Artery Disease (Heart)
- ☐ Deep Vein Thrombosis (Vein Clots)
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes, details _____
- ☐ Diverticulosis
- ☐ Emphysema
- ☐ Fibrocystic Breast Disease
- ☐ Fibromyalgia
- ☐ Gallstones
- ☐ GERD
- ☐ Glaucoma
- ☐ Hard of Hearing
- ☐ Headaches
- ☐ Heart Attack (Myocardial Infarction)
- ☐ Heartburn
- ☐ Heart Murmur
- ☐ Heart Valve Disease _____
- ☐ Hepatitis, details _____
- ☐ HIV
- ☐ High Cholesterol
- ☐ Hypertension (High Blood Pressure)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Infertility
- ☐ IBS (Irritable Bowel Syndrome)
- ☐ Kidney Disease, details _____
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Mental Illness, details _____
- ☐ Migraines
- ☐ Nerve / Muscle Disease, deatils _____
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Ovarian Cyst
- ☐ Pain (chronic), details _____
- ☐ Pancreatitis
- ☐ Peripheral Artery Disease
- ☐ Peripheral Venous Disease
- ☐ Pneumonia
- ☐ Polycystic Ovary Syndrome
- ☐ Positive TB test
- ☐ Pulmonary Embolism (Lung clot)
- ☐ Rheumatic Fever
- ☐ Prostate disease, details _____
- ☐ Seizures, details _____
- ☐ Shingles
- ☐ Sickle Cell Anemia
- ☐ Sickle Cell Trait
- ☐ Sleep Apnea
- ☐ STD / sexual infection
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcer, what type _____
- ☐ Urinary Incontinence
- ☐ Visual Problems

Other conditions _____

Reviewed _____ (initials/date)

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Surgical History, check all that apply, include year or age, and type if known:

☐ Appendectomy	☐ Eye(s)	☐ Weight reduction
☐ Brain	☐ Fractured bone(s)	☐ Colon
☐ Breast	☐ Hernia repair	☐ Small intestine
☐ CABG (open heart)	☐ Septum Repair	☐ C-section
☐ Other heart surgery	☐ Knee	☐ Hysterectomy
☐ Cholecystectomy (gall bladder)	☐ Hip	☐ Tubal ligation
☐ Neck	☐ Bunionectomy	☐ Vasectomy
☐ Back	☐ Other joint(s)	☐ Prostate
☐ Tonsillectomy	☐ Varicose veins	☐ Bladder
☐ Thyroid gland	☐ Other vascular surgery	☐ Lung

Other surgeries: _____

Other health issues

In the past year, have you had two weeks or more during which you felt sad, blue or depressed, or when you have lost all interest or pleasure in things that you usually care about or enjoyed? ☐ No ☐ Yes, describe

_____

Do you feel unsafe, or have you been harmed in a physical, emotional or sexual manner, in any relationship or recent encounter? ☐ No ☐ Yes, describe

_____

In the past year, have you had any major life changes or stresses that you feel have impacted your overall health? ☐ No ☐ Yes, describe

_____

Sexual history: currently sexually active ☐ No ☐ Yes ☐ Never sexually active
My sexual partners have been: ☐ Male ☐ Female ☐ Both
Have you had more than one sexual partner in the past year? ☐ No ☐ Yes
Current contraception method: _____
Have you ever had any sexually transmitted disease? ☐ No ☐ Yes, what and when _____
Number of children: _____

For Women:
What was your age at first menses? _____ Menstrual periods: ☐ Regular ☐ Irregular ☐ Menopausal
Age at menopause? _____ Do you have hot flashes or other symptoms (specify)? _____
pregnancies: _____ # miscarriages: _____ # abortions _____
Any gynecological problems or conditions? ☐ No ☐ Yes, specify: _____
Who is your OB/GYN provider? _____ Date last seen: _____
Describe any further known details of your medical history:

_____

_____

Reviewed: _____ (initials/date)

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Current Symptoms (check if you currently experiencing any of the following symptoms)

General
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Weight gain > 10 lb
- ☐ Weight loss > 10 lb

Skin
- ☐ Rash
- ☐ New/changing mole(s)
- ☐ Nail changes
- ☐ Hair loss

Eyes
- ☐ Vision changes
- ☐ Pink eye(s)
- ☐ Pain in the eye(s)
- ☐ Excessive tearing

Ear / Nose / Throat
- ☐ Nasal congestion
- ☐ Runny nose or sneezing
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Hoarse voice
- ☐ Ear pain
- ☐ Draining from ear(s)
- ☐ Decreased hearing
- ☐ Ringing in the ears
- ☐ Swallowing problems
- ☐ Swollen glands
- ☐ Nasal bleeds

Respiratory
- ☐ Wheezing
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Productive cough
- ☐ Bloody sputum
- ☐ Dry cough

Cardiovascular
- ☐ Chest pain
- ☐ Racing heart
- ☐ Irregular heartbeat
- ☐ Shortness of breath
- ☐ Leg pain with walking
- ☐ Ankle or leg swelling
- ☐ Poor activity tolerance
- ☐ Dizziness or dizzy spells
- ☐ Passing out

Gastrointestinal
- ☐ Abdominal pain
- ☐ Change in stool
- ☐ Diarrhea
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Blood in stool
- ☐ Rectal pain
- ☐ Blood in vomit
- ☐ Abdominal cramps
- ☐ Heartburn
- ☐ Acid reflux
- ☐ Trouble swallowing

Musculoskeletal
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Joint swelling
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Muscle pain or cramps
- ☐ Muscle weakness
- ☐ Pain in the leg(s)
- ☐ Pain in the arm(s)

Hematologic
- ☐ Easy bruising
- ☐ Prolonged bleeding
- ☐ Enlarged lymph nodes

Neurologic
- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness / vertigo
- ☐ Numbness / tingling
- ☐ Passing out
- ☐ Difficulty walking
- ☐ Weakness
- ☐ Frequent falls
- ☐ Tremors / shakes
- ☐ Seizures

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Hallucinations
- ☐ Mood swings
- ☐ Suicidal thoughts

Endocrine
- ☐ Change in appetite
- ☐ Heat or cold intolerance
- ☐ Increased thirst
- ☐ Hair loss
- ☐ Excess hair growth
- ☐ Changes in sex drive

Allergic / Immunologic
- ☐ Seasonal Allergy
- ☐ Rash or itchy skin
- ☐ Frequent infections

Breast
- ☐ Pain
- ☐ Lump or mass
- ☐ Nipple discharge
- ☐ Rash or infection

Genitourinary
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Loss of urine
- ☐ Difficulty passing urine

Men
- ☐ Change in urinary stream
- ☐ Difficulty starting stream
- ☐ Penile discharge
- ☐ Pain or lump on testicles
- ☐ Erection difficulties

Women
- ☐ Vaginal discharge
- ☐ Pelvic pain
- ☐ Irregular periods
- ☐ Excessive bleeding
- ☐ Bleeding after menopause

- ☐ Vaginal dryness
- ☐ Hot flashes
- ☐ Pain with intercourse

Reviewed: _____
(initials/date)

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HEALTH HABITS AND PERSONAL SAFETY

Exercise: ☐ Sedentary (no exercise) ☐ Mild exercise (climb stairs, walk 3 blocks, light house work, golf)

☐ Gym X1-3/week (or other moderate to intense exercise, including work or recreation)

☐ Gym X4-7/week (or other moderate to intense exercise, including work or recreation)

Diet: ☐ No limitations ☐ Vegetarian ☐ Vegan ☐ Ovo-lactovegetarian ☐ Pescatarian ☐ Ketogenic

☐ Low salt ☐ Low carb ☐ Low calorie, # calorie per day _____

☐ Other, specify: _____

Tobacco:

Cigarette use: ☐ Never ☐ Former smoker, quite date or age _____ How long did you smoke for? _____

☐ Current smoker, # packs/day _____ # years _____

Vape: ☐ No ☐ Yes, details _____

Other tobacco use: ☐ Pipe, details _____ ☐ Cigars, details _____ ☐ Chewing tobacco _____

Alcohol: Do you drink alcohol? ☐ No ☐ Yes: ☐ 0-1 time/month ☐ 2-4 times/month

☐ Every 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 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: ☐ Never

Have you used recreational or street drugs within the last 2 years? ☐ No ☐ Yes, details _____

Have you ever used recreational drugs with a needle? ☐ No ☐ Yes, details _____

Safety: Do your wear seatbelts? ☐ Yes ☐ No Does your house have working CO_2 detector? ☐ Yes ☐ No

Have you had a fall in the past 1 year? ☐ No ☐ Yes: were you injured from the fall? ☐ No ☐ Yes, details:

_____

Have you had more than one fall in the past 1 year? ☐ No ☐ Yes, details _____

Travel: Any recent travel? ☐ No ☐ Yes, details _____

Any travel related illness? ☐ No ☐ Yes, details _____

Name:_____ **Date of birth:**_____ **Date completed:**_____

FAMILY HISTORY

Family Member, Age		Medical Conditions										
Mother	☐ Living ☐ Deceased	Alcohol abuse	Breast cancer	Ovarian cancer	Prostate cancer	Colon cancer	Other cancer(s)	Diabetes	High Cholesterol	High Blood Pressure	Heart disease	Mental Illness
Father	☐ 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											
Sibling ☐ F ☐ M	☐ Living ☐ Deceased											
Sibling ☐ F ☐ M	☐ Living ☐ Deceased											
Sibling ☐ F ☐ M	☐ Living ☐ Deceased											
Sibling ☐ F ☐ M	☐ Living ☐ Deceased											
Child ☐ F ☐ M	☐ Living ☐ Deceased											
Child ☐ F ☐ M	☐ Living ☐ Deceased											
Child ☐ F ☐ M	☐ Living ☐ Deceased											
Child ☐ F ☐ M	☐ Living ☐ Deceased											
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Reviewed _____ (initials/date)

Name:_____ Date of birth:_____ Date completed:_____

Additional health concerns or comments:

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Please bring this form filled to your first appointment.