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BOONE MEDICAL GROUP

New Patient Questionnaire

All Questions Contained in this Questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.) _____ (Circle) Male Female

Date of Birth ___/___/_____ Age:_____

Home Phone	Preferred Pharmacy Name and Location
Cell Phone	Primary Dentist
Email Address	

Race:

- □ Alaskan Native
- □ Asian
- □ Asian Pacific
- □ Black/African American
- □ Hispanic
- □ Native American
- □ Other
- □ Pacific Islander
- □ Unknown
- □ White/Caucasian (Non-Hispanic)

Ethnicity:

- □ Hispanic or Latino
- □ Not Hispanic or Latino
- □ Other

Preferred Spoken Language:

- □ Bulgarian
- □ Central Khmer
- □ Chinese
- □ English
- □ French
- □ German
- □ Haitian/Haitian Creole
- □ Hebrew
- □ Hindi
- □ Italian
- □ Korean
- □ Polish
- □ Portuguese
- □ Russian
- □ Somali
- □ Spanish/Castilian
- □ Swahili
- □ Thai
- □ Urdu
- □ Vietnamese
- □ Other, Please Specify _____

Emergency Contact:

Name_____ Relationship to Pt_____

Best Contact Phone Number _____

Please list all current medications, including over-the-counter and herbal supplements:

Patient Name: Patient DOB:

Today's Date:

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Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency

Please list all current medication allergies:

Allergy	Reaction
Allergy	Reaction
Allergy	Reaction
Allergy	Reaction
Allergy	Reaction

Non-medication allergies:

Allergy	Reaction
Allergy	Reaction
Allergy	Reaction

Past Medical History - Please check all that apply:

Patient Name: Patient DOB:
Today's Date:

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□ No Past Medical History

□ Allergies
□ Anemia
□ Angina (chest pain)
□ Anxiety
□ Arthritis
□ Asthma
□ Atrial Fibrillation
□ BPH (Prostate Problems)
□ Blood clots
□ Cancer – specify type _____
□ Cerebrovascular Accident (Stroke)
□ COPD
□ Coronary Artery Disease (CAD)
□ Crohn's Disease
□ Depression
□ Diabetes

□ Gallbladder Disease
□ GERD (acid reflux)
□ Hepatitis C
□ Hyperlipidemia (high cholesterol)
□ Hypertension (high blood pressure)
□ Irritable Bowel Disease
□ Liver Disease
□ Migraine Headaches
□ Myocardial Infarction (heart attack)
□ Osteoarthritis
□ Osteoporosis
□ Peptic Ulcer Disease
□ Renal Disease (Kidney Disease)
□ Seizure Disorder
□ Thyroid Disease
□ Overactive
□ Underactive

□ Other, Please Specify _____

Past Surgical History – Please list all prior surgeries and the approximate year they took place:

□ No Past Surgical History

Surgery:_____ **Year:** _____
Surgery:_____ **Year:** _____
Surgery:_____ **Year:** _____
Surgery:_____ **Year:** _____

Family Medical History

□ No Relevant Family History

Mother's Age:_____ Health Problems: _____
If Deceased, Age of Death: _____ Cause of Death: _____

Father's Age:_____ Health Problems: _____
If Deceased, Age of Death: _____ Cause of Death: _____

Brother/Sister (please circle) Age:_____ Health Problems: _____
If Deceased, Age of Death: _____ Cause of Death: _____

Brother/Sister (please circle) Age:_____ Health Problems: _____
If Deceased, Age of Death: _____ Cause of Death: _____

Social History

Patient Name: Patient DOB:
Today's Date:

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What is your current marital status? Please circle.
Married Single Widowed Divorced Other

Do you drink alcohol?
Yes No Formerly

Do you drink caffeine?
Yes No Formerly

Do you use tobacco?
Yes No Formerly

What is your current smoking status? Please circle.
Current everyday smoker Current some day smoker Former Smoker Never Smoked

Preventative Health

Date of Most Recent Blood Tests (if known):
Lipid Panel ___/___/___ Cholesterol ___/___/___ Glucose ___/___/___

PSA (males only) ___/___/___

Date and Location of Most Recent Health Screenings (if known):
Colonoscopy ___/____/___ Location:_____

Bone Density ____/___/___ Location:_____

Physical Exam ___/____/___ Location:_____

Prostate Screening (males only) ___/____/___ Location:_____

Mammogram (females only) ___/____/___ Location:_____

Pap Smear (females only) ___/____/___ Location:_____

Have you ever been diagnosed with diabetes? YES NO
If yes, please answer the following:

Date	Test	Provider
	HbA1c	

Patient Name: Patient DOB:
Today's Date:

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	Foot Exam	
	Urinalysis with or without protein	
	Eye Exam	

Immunizations

Date	Immunization	Provider
	Pneumonia	
	Influenza	
	Tetanus	
	Other (please specify)	

This form was filled out by_____ Relationship to patient_____
(print name)

Signature: X_____ Date ___/___/___

Patient Name: Patient DOB:
Today's Date:

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Please list previous primary care physician(s) and any specialist(s) you are currently seeing and/or have seen in the recent past. If we need to obtain records from these providers, we will provide an authorization form during your office visit.

Physician First and Last Name	Practice Name and/or City, State
Physician First and Last Name	Practice Name and/or City, State
Physician First and Last Name	Practice Name and/or City, State
Physician First and Last Name	Practice Name and/or City, State

Patient Name: Patient DOB:
Today's Date: