

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:

<u>Home Phone</u>	<u>Preferred Pharmacy Name and Location</u>
<u>Cell Phone</u>	<u>Primary Dentist</u>
<u>Email Address</u>	

Race:

- | | |
|---|---|
| <input type="checkbox"/> Alaskan Native | <input type="checkbox"/> Native American |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Other |
| <input type="checkbox"/> Asian Pacific | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> White/Caucasian (Non-Hispanic) |

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino
- Other

Preferred Spoken Language:

- | | | |
|---|--|--|
| <input type="checkbox"/> Bulgarian | <input type="checkbox"/> Korean | <input type="checkbox"/> Other, Please Specify |
| <input type="checkbox"/> Central Khmer | <input type="checkbox"/> Polish | _____ |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Portuguese | |
| <input type="checkbox"/> English | <input type="checkbox"/> Russian | |
| <input type="checkbox"/> French | <input type="checkbox"/> Somali | |
| <input type="checkbox"/> German | <input type="checkbox"/> Spanish/Castilian | |
| <input type="checkbox"/> Haitian/Haitian Creole | <input type="checkbox"/> Swahili | |
| <input type="checkbox"/> Hebrew | <input type="checkbox"/> Thai | |
| <input type="checkbox"/> Hindi | <input type="checkbox"/> Urdu | |
| <input type="checkbox"/> Italian | <input type="checkbox"/> Vietnamese | |

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:

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

Patient Name:
 Today's Date:

Patient DOB:

Past Medical History - Please check all that apply:

- No Past Medical History
- | | |
|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Gallbladder Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> GERD (acid reflux) |
| <input type="checkbox"/> Angina (chest pain) | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hyperlipidemia (high cholesterol) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypertension (high blood pressure) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Irritable Bowel Disease |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> BPH (Prostate Problems) | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Myocardial Infarction (heart attack) |
| <input type="checkbox"/> Cancer – specify type _____ | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Cerebrovascular Accident (Stroke) | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> Coronary Artery Disease (CAD) | <input type="checkbox"/> Renal Disease (Kidney Disease) |
| <input type="checkbox"/> Crohn’s Disease | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Overactive |
| | <input type="checkbox"/> Underactive |
| <input type="checkbox"/> 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: _____ |

 Patient Name: _____
 Today’s Date: _____

Patient DOB: _____

Social History

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: _____

Patient Name:
Today's Date:

Patient DOB:



Have you ever been diagnosed with diabetes? YES NO

If yes, please answer the following:

Date	Test	Provider
	HbA1c	
	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:
 Today's Date:

Patient DOB:



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:
Today's Date:

Patient DOB: