Upcoming Apt Date : _____

Boone Medical Group
INFECTIOUS DISEASES

New Patient Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name (Last, First, MI): _____

Gender: _____ Date of Birth: _____/_____/_____

Referring Physician: _____

Preferred Pharmacy Name and Location: _____

Reason for Your Visit:_____

MEDICATIONS If there is not enough space, please attach a list. Include oxygen therapy, over-the-counter medications, and herbal supplements.

□ No current medications

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:_____

ALLERGIES

□ No Known Allergies

Medication Allergy:_____ Reaction:_____
Medication Allergy:_____ Reaction:_____
Medication Allergy:_____ Reaction:_____
Medication Allergy:_____ Reaction:_____

Please list any past **surgical** history:

1. _____ Year:_____
2. _____ Year:_____
3. _____ Year:_____
4. _____ Year:_____
5. _____ Year:_____
6. _____ Year:_____

FAMILY HISTORY

□ No Relevant Family History

Mother:
Age:_____ Health Problems:_____
If deceased, age at time of death:_____ Cause of Death:_____

Father:
Age:_____ Health Problems:_____
If deceased, age at time of death:_____ Cause of Death:_____

Brother/Sister (Please circle one):
Age:_____ Health Problems:_____
If deceased, age at time of death:_____ Cause of Death:_____

Brother/Sister (Please circle one):
Age:_____ Health Problems:_____
If deceased, age at time of death:_____ Cause of Death:_____

Brother/Sister (Please circle one):
Age:_____ Health Problems:_____
If deceased, age at time of death:_____ Cause of Death:_____

Brother/Sister (Please circle one):
Age:_____ Health Problems:_____
If deceased, age at time of death:_____ Cause of Death:_____

IMMUNIZATIONS Please list the last year you had the following immunizations.

Seasonal Influenza Vaccine: Year:_____ Provider: _____

Prevnar 13 Vaccine: Year:_____ Provider: _____

Pneumovax Vaccine: Year:_____ Provider: _____

Covid Vaccine: Manufacturer: _____ Date Dose 1: _____ Date Dose 2: _____

Meningococcal ACWY Year:_____ Provider: _____

Tdap (Tetanus) Year:_____ Provider: _____

Garasil Year:_____ Provider: _____

□ 1st dose □ 2nd dose □ 3rd dose

Shingrix (Shingles) Year:_____ Provider: _____

SOCIAL HISTORY

Do you drink alcohol? □ Yes □ No □ In the past

If yes, How often? _____ How much? _____

Do you live with someone who smokes/uses tobacco? □ Yes □ No □ In the past

Do you smoke/use tobacco? □ Yes □ No □ In the past (when did you quit? _____)

What type of tobacco do/did you use? _____How many packs per day? _____ For how many years? _____

Do you use E-cigarettes? □ Everyday □ Someday □ In the past. For how many years?_____

Start date: _____ Stop date: _____ # of cartridges per day_____

Do you use any recreational drugs? □ Yes □ No □ In the past

Do you use IV drugs? □ Yes □ No □ In the past

Do you live with pets or animals? □ Yes □ No □ In the past

Do you work with pets or animals? □ Yes □ No □ In the past

Occupation:_____

Have you traveled in the last 10 years? _____ If yes, please describe your travels:

Where: _____ Date: _____

Where: _____ Date: _____

Where: _____ Date: _____

Where have you lived in the last 10 years?

Where: _____ Date: _____

Where: _____ Date: _____

Where: _____ Date: _____

MEDICAL HISTORY Please check any that apply.

□ Anemia
□ Asthma
□ Bronchiectasis
□ Cancer
□ Cholecystitis
□ Chronic Bronchitis
□ Chronic Steroid Use
□ COPD
□ Coronary Artery Disease (CAD)
□ Deep Vein Thrombosis
□ Diabetes
□ Emphysema
□ GERD
□ Glaucoma
□ Head Injury
□ Hearing Loss
□ Heart Murmur
□ History of Blood Transfusion
□ HIV/AIDS
□ Hypertension (high blood pressure)
□ Interstitial Lung Disease
□ Kidney disease
□ Liver Disease
□ Lung Cancer
□ Lung Nodule
□ Lupus
□ Myocardial Infarction (heart attack)
□ Pleural Effusion
□ Pneumonia
□ Prostatitis
□ Pulmonary Embolism
□ Rheumatic Fever
□ Rheumatoid Arthritis
□Sarcoidosis
□ Seizure
□ Sinus Disease
□ Sleep Apnea-Obstructive
□ Stroke
□ Thyroid Disease
□ Tuberculosis
□ Venereal Disease
□ Other_____

BMG Infectious Diseases No-Show Policy

BMG Infectious Diseases utilizes a no-show policy to reduce the number of patients who miss appointments. By reducing the amount of no-shows, we can better serve our patients with the clinic time available. Therefore, patients who have three or more no-show appointments in one year will be considered for dismissal from our clinic.

We respectfully request that any cancellations be made **24 hours prior** to your appointment to allow us time to fill that slot with another patient.

By signing below, you are acknowledging that you have read and understand the policy stated above. Thank you for your courtesy in calling in advance to cancel any appointment you cannot attend.

Signature of Patient

Date