**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:\_\_\_\_\_\_\_\_\_ \_\_ SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 **Name & Date of Birth**

**Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Of Insurance Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

□ Hispanic or Latino

□ Not Hispanic or Latino Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other

**Preferred Spoken Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Pt\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best Contact Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

|  |  |
| --- | --- |
| Dose | Frequency |
| Dose | Frequency |
| Dose | Frequency |
| Dose  | Frequency  |
| Dose  | Frequency  |
|  |  |

**Please list all current medication allergies:**

|  |  |
| --- | --- |
| Allergy | Reaction |
| Allergy | Reaction |
| Allergy | Reaction |

**Non-medication allergies:**

|  |  |
| --- | --- |
| Allergy | Reaction |
| Allergy | Reaction |
| Allergy | Reaction |

**Past Medical History - Please check all that apply:**

□ No Past Medical History

□ Allergies □ Gallbladder Disease

□ Anemia □ GERD (acid reflux)

□ Angina (chest pain) □ Hepatitis C

□ Anxiety □ Hyperlipidemia (high cholesterol)

□ Arthritis □ Hypertension (high blood pressure)

□ Asthma □ Irritable Bowel Disease

□ Atrial Fibrillation □ Liver Disease

□ BPH (Prostate Problems) □ Migraine Headaches

□ Blood clots □ Myocardial Infarction (heart attack)

□ Cancer – specify type \_\_\_\_\_\_ □ Osteoarthritis

□ Cerebrovascular Accident (Stroke) □ Osteoporosis

□ COPD □ Peptic Ulcer Disease

□ Coronary Artery Disease (CAD) □ Renal Disease (Kidney Disease)

□ Crohn’s Disease □ Seizure Disorder

□ Depression □ Thyroid Disease

□ Diabetes □ 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**

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 |  |
|  | Foot Exam |  |
|  | Urinalysis with or without protein |  |
|  | Eye Exam |  |

**Immunizations**

|  |  |  |
| --- | --- | --- |
| **Date** | **Immunization** | **Provider** |
|  | Pneumonia |  |
|  | Influenza |  |
|  | Tetanus |  |
|  | Other (please specify) |  |

**Travel and Exposure Questionnaire**

Have you traveled outside the U.S. in the last month? YES NO

Have you had contact with someone with a communicable disease in the last month?

YES NO UNKNOWN

If yes, please circle: Chicken pox Cholera Cold Ebola Enterovirus Influenza Measles Meningitis MERS Tuberculosis Unidentified

Other (Please Comment)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exposure Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Symptoms in the last week, please circle:

Abdominal Pain Cough Diarrhea Fever Muscle Pain

Severe Headache Bruising or Bleeding Vomiting Weakness Rash

This form was filled out by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (print name)

Signature: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_ /\_\_\_ /\_\_\_

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