Dear ______________,  

Welcome to Boone Health Primary Care at Nifong. We look forward to seeing you for your scheduled appointment with ________________ on _____________ at ___________.

Please arrive 30 minutes early to your appointment. You will need to arrive at ____________.

1) Please complete the enclosed paperwork and bring with you to your appointment. Please do not mail or fax as this can delay processing.

2) You must arrive 30 minutes early to process your check-in as a first-time patient. Failure to arrive early could result in the need to reschedule your appointment.

3) Bring your insurance card and photo ID, and the enclosed paperwork completed.

4) Any copay or coinsurance is due at the time of service. We accept cash, check, Mastercard, Visa and Discover card.

5) If you do not plan to keep this appointment, please give our office 24 hours notice prior to the appointment.

6) If you are experiencing any COVID-like symptoms, or have had a recent exposure, please call the office and let us know so we can plan accordingly.

We look forward to meeting you. Please call our office at 573-815-6640 with any questions or concerns.

Sincerely,

Boone Health Primary Care Nifong
# 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: ______

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Preferred Pharmacy Name and Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell Phone</td>
<td>Primary Dentist</td>
</tr>
<tr>
<td>Email Address</td>
<td></td>
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</tbody>
</table>

**Race:**
- [ ] Alaskan Native
- [ ] Native American
- [ ] Asian
- [ ] Other
- [ ] Asian Pacific
- [ ] Pacific Islander
- [ ] Black/African American
- [ ] Unknown
- [ ] Hispanic
- [ ] White/Caucasian (Non-Hispanic)

**Ethnicity:**
- [ ] Hispanic or Latino
- [ ] Not Hispanic or Latino
- [ ] Other

**Preferred Spoken Language:**
- [ ] Bulgarian
- [ ] Korean
- [ ] Other, Please Specify
- [ ] Central Khmer
- [ ] Polish
- [ ] Vietnamese
- [ ] Chinese
- [ ] Portuguese
- [ ] Thai
- [ ] Somali
- [ ] Spanish/ Castilian
- [ ] Swahili
- [ ] Haitian/ Haitian Creole
- [ ] Urdu
- [ ] Hebrew
- [ ] Italian
- [ ] Hindi

**Emergency Contact:**
Name ____________________________ Relationship to Pt ____________________________

Best Contact Phone Number ____________________________

Patient Name: ____________________________ Patient DOB: ____________________________

Today’s Date: ____________________________
Please list all current medications, including over-the-counter and herbal supplements:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
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</thead>
<tbody>
<tr>
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</table>

Please list all current medication allergies:

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Reaction</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Non-medication allergies:

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Reaction</th>
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</thead>
<tbody>
<tr>
<td></td>
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</table>

Patient Name: 
Patient DOB: 
Today’s Date:
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 ☐ Sleep Apnea
☐ Diabetes ☐ Thyroid Disease
☐ Arthritis ☐ 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: __________________________

Patient Name: ____________________ Patient DOB: __________
Today’s Date: __________
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:  Patient DOB:
Today’s Date:
Have you ever been diagnosed with diabetes?  YES  NO
If yes, please answer the following:

<table>
<thead>
<tr>
<th>Date</th>
<th>Test</th>
<th>Provider</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>HbA1c</td>
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<td></td>
<td>Foot Exam</td>
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<tr>
<td></td>
<td>Urinalysis with or without protein</td>
<td></td>
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<tr>
<td></td>
<td>Eye Exam</td>
<td></td>
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</tbody>
</table>

Immunizations

<table>
<thead>
<tr>
<th>Date</th>
<th>Immunization</th>
<th>Provider</th>
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<tbody>
<tr>
<td></td>
<td>Pneumonia</td>
<td></td>
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<tr>
<td></td>
<td>Influenza</td>
<td></td>
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<td></td>
<td>Tetanus</td>
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<td></td>
<td>Other (please specify)</td>
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</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Physician First and Last Name</th>
<th>Practice Name and/or City, State</th>
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