

## NEW PATIENT QUESTIONNAIRE

Please fill out this form as thoroughly as possible, printing all responses clearly. All information contained in these pages is completely confidential and will not be released unless you authorize us to do so.

PERSONAL INFORMATION											
Last Name		First		Middle		Prefix		Sex		Birth Date	Today's Date
								M	F		
Street Address			City			State			Zip	Social Security Number	
Home Phone		Mobile Phone			Email Address						
Primary Language		Do you need an interpreter?		Race (optional)		Ethnicity (optional)		Religion (optional)			
		Yes	No								
Marital Status	Name of Partner or Spouse			Do you live alone?		Number of Members in Your Household					
				Yes	No						
Emergency Contact		Relationship to Patient		Home Phone		Mobile Phone		Work Phone			
Highest Level of Education	Occupation			Employer							
Employer's Street Address			City			State			Zip	Work Phone	
<i>If you are under the age of 18, please complete the following section.</i>											
Name of Parent or Legal Guardian		Relationship to Patient		Home Phone		Mobile Phone		Work Phone			
		Street Address			City			State			Zip
Name of Parent or Legal Guardian		Relationship to Patient		Home Phone		Mobile Phone		Work Phone			
		Street Address			City			State			Zip

PRIMARY INSURANCE									
Name of Subscriber			Relationship to Patient		Birth Date	Social Security Number			
Insurance			ID Number		Group Number		Copay Amount		
Insurance Street Address			City			State		Zip	Subscriber's Employer
SECONDARY INSURANCE									
Name of Subscriber			Relationship to Patient		Birth Date	Social Security Number			
Insurance			ID Number		Group Number		Copay Amount		
Insurance Street Address			City			State		Zip	Subscriber's Employer

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

PHARMACY INFORMATION			
Name	Phone Number	Fax Number	
Street Address	City	State	Zip

HEALTH MAINTENANCE HISTORY <i>List the most recent date for each of the following:</i>			
WOMEN ONLY	BOTH MEN AND WOMEN		MEN ONLY
_____ Menstrual Period	_____ Colonoscopy	_____ Fecal Occult Blood	_____ Prostate Exam
_____ Mammogram	_____ Sigmoidoscopy	_____ Blood Pressure Check	_____ PSA
_____ Breast Exam	_____ Cholesterol Test	_____ Diabetes Screening	_____ Abdominal Ultrasound
_____ Pap Smear	_____ Influenza Vaccine	_____ Pneumonia Vaccine	
	_____ Zoster Vaccine	_____ HPV Vaccine	
	_____ STD Screening	_____ Eye Exam	

\*Please bring a copy of your immunization/vaccine history to your appointment.

MEDICAL HISTORY <i>Check <input checked="" type="checkbox"/> conditions you have or have had in the past.</i>			
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chemical dependence	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Psychiatric care
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Herpes	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Seasonal allergies
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Sexual difficulty
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Sexually transmitted infection
<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Skin rash
<input type="checkbox"/> Bleeding/Clotting disorder	<input type="checkbox"/> Erectile dysfunction	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Bone/Joint disorder	<input type="checkbox"/> GERD (reflux)	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Breast lump	<input type="checkbox"/> Goiter	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Thyroid problem
<input type="checkbox"/> Cancer (see below)	<input type="checkbox"/> Gout	<input type="checkbox"/> Peripheral vascular disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Headaches	<input type="checkbox"/> PPD positive	<input type="checkbox"/> Urinary incontinence
<input type="checkbox"/> CAD/Heart disease	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Prostate problem	<input type="checkbox"/> Vaginal infection
<input type="checkbox"/> Other (Please describe)			
If you have/had cancer, please name type(s) and describe treatment with corresponding dates in the space below.			

Date of last physical exam:	Former primary care provider:
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Reason for today's visit

Please describe any symptoms/complaints that you would like to discuss with your primary care provider at today's appointment.

WOMEN ONLY							
Number of pregnancies:		Number of living children:		Number of abortions:		Number of miscarriages:	
DATE	TYPE OF DELIVERY	SEX	COMPLICATIONS	DATE	TYPE OF DELIVERY	SEX	COMPLICATIONS

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

<b>SURGICAL HISTORY</b>		
YEAR	LOCATION	TYPE <i>(Please describe any complications)</i>

<b>OTHER HOSPITALIZATIONS, SERIOUS ILLNESSES, INJURIES</b>		
YEAR	LOCATION	REASON FOR HOSPITALIZATION / DESCRIBE SERIOUS ILLNESS OR INJURY

<b>HEALTH HABITS</b> <i>Check <input checked="" type="checkbox"/> appropriate boxes below and describe</i>		
Caffeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of caffeinated drinks per day:
Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Chewing tobacco Number of years you have used tobacco: Amount per day <i>(i.e. number of packs smoked)</i> : Year quit:
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit	Number of drinks per week: Preferred drink <i>(i.e. beer, wine)</i> : Year quit:
Recreational drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit	Type: Amount per week: Last used:
Exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe type of exercise: Number of days per week:

During the past month, have you felt down, depressed, or hopeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No
During the past month, have you felt little interest or pleasure in doing things?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

<b>MEDICATIONS</b> <i>List all medications, including over-the-counter medications and supplements. Write dosage and frequency for each medication.</i>

*\*Please attach additional sheets if necessary.*

<b>ALLERGIES</b>	
<input type="checkbox"/> No Known Allergies	<input type="checkbox"/> Yes, I have the following medication and/or food allergies. Please describe your reaction to each medication/food listed.

<b>FAMILY HISTORY</b>			
RELATION	AGE, IF LIVING	AGE AT DEATH	MEDICAL CONDITIONS / CAUSE OF DEATH
Mother			
Father			
Sisters			
Sisters			
Sisters			
Brothers			
Brothers			
Brothers			

<b>Check <input checked="" type="checkbox"/> if a blood relative has had any of the following. List relationship of relative to you.</b>	
<input type="checkbox"/> Alcoholism/Substance abuse:	<input type="checkbox"/> High cholesterol:
<input type="checkbox"/> Autoimmune disorder:	<input type="checkbox"/> Kidney disease:
<input type="checkbox"/> Asthma:	<input type="checkbox"/> Mental illness:
<input type="checkbox"/> Bleeding/Clotting disorder:	<input type="checkbox"/> Osteoporosis:
<input type="checkbox"/> Cancer:	<input type="checkbox"/> Stroke:
<input type="checkbox"/> Diabetes:	<input type="checkbox"/> Thyroid problem:
<input type="checkbox"/> Heart disease:	<input type="checkbox"/> Other:
<input type="checkbox"/> High blood pressure:	

*I attest that the above information is correct to the best of my knowledge.*

\_\_\_\_\_  
SIGNATURE OF PATIENT / LEGAL GUARDIAN / LEGAL REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NAME OF LEGAL GUARDIAN / LEGAL REPRESENTATIVE (Please Print)

\_\_\_\_\_  
RELATIONSHIP TO PATIENT