New Patient Health Questionnaire

Patient # _____

Name _____ Date of Birth _____ Date: _____

Why are you here today? _____

_____

Are you on any Medicine? YES or NO

Name of Medicine				
Started when?				
Dose (mg)				
How often?				
Purpose, why				
Prescribed by				
Name of Medicine				
Started when?				
Dose (mg)				
How often?				
Purpose, why				
Prescribed by				
Please list any additional medicines you are taking:				

Chronic Problems: (Diseases or illnesses that you must be treated for all the time)

Date Diagnosed				
Diagnosis/Condition/Problem				
Date Diagnosed				
Diagnosis/Condition/Problem				

Are you allergic to anything? YES or NO

Name of Medicine/Allergy			
Type of reaction- rash, swelling, couldn't breath, etc.			

General Health:

1. How many days per week do you exercise for at least 20 minutes? _____
2. When did you last see a dentist? _____
   Are you having any dental problems now? NO or YES (please explain): _____
3. When did you last have an eye exam? _____ Are you having any eye or vision problems now? NO or YES (please explain): _____
4. What type of work do you do? _____
5. Have you ever had a test for hidden blood in your stool? NO or YES (if YES, please answer below:)
   a. Date of last colonoscopy: _____ Result: Normal / Abnormal
   b. Date of last sigmoidoscopy: _____ Result: Normal / Abnormal

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Surgeries or special procedures: Please put a (✓) check mark next to any surgery you have had

Check	Operation:	Date:
	Appendix	
	Chest Surgery	
	Heart Bypass	
	Hernia	
	Gall Bladder	
	Radiation Therapy	
	Prostate Surgery	
	Other:	
	Other:	

Check	Operation:	Date:
	Tonsils	
	Vascular Surgery	
	Breast Biopsy	
	Mastectomy	
	Hysterectomy	
	Ovaries Removed	
	Other:	
	Other:	
	Other:	

Family History:

(Examples of health conditions: Diabetes, Heart Disease, High blood pressure, Depression, Cancer, Schizophrenia, Thyroid, Alcohol or Drug problem, Breathing problems, Suicide , Heart Attack, Stroke, Bipolar, Cholesterol, etc.)

Relationship	Circle	Date of Birth	Age (years)	Health Conditions
Father	Alive or Dead			
Mother	Alive or Dead			
Brother(s)	Alive or Dead			
Sister(s)	Alive or Dead			
Grandfather	Alive or Dead			
Grandmother	Alive or Dead			
Other family members: _____	Alive or Dead			
Other family members: _____	Alive or Dead			

Siblings: # of Brothers _____ # of Sisters _____ Are they healthy? YES or NO

Children: # of Sons _____ # of Daughters _____ Are they healthy? YES or NO

Social History:

Check if using		What type?	How much?	How often?	For how long?	Interested in quitting?
	Tobacco					
	Alcohol					
	Drugs					

For each question please circle either YES or NO:

YES or NO	In the last year, have you ever drank or used drugs more than you meant to?
YES or NO	Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

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Immunizations:

Last tetanus shot _____ Last pneumonia shot _____ Last flu vaccine _____

(Please make a copy of any immunization records for patient)

(Men Only) Last Prostate Exam: _____ Result: Normal / Abnormal
Last PSA: _____ Result: Normal / Abnormal

(Women Only) Last Mammogram: _____ Result: Normal / Abnormal
Last Pelvic exam/Pap: _____ Result: Normal / Abnormal
Current birth control method: _____

Menstrual Periods: Date of last period: _____ Age at onset: _____ Regular: Yes / No
Difficulty with periods: Yes / No Age at menopause: _____

Pregnancies: # of children _____ Cesarean _____ Premature _____ Stillborn _____
Miscarriage _____ Complications: _____

Other comments or details that may affect your health or your treatment:

_____

_____

_____

_____

Patient Signature _____