New Patient Medical History Questionnaire

General Information

Name: ___________________________ Date of Birth: ______________ Age: _____ Gender: ________

Medical History

Allergies (List all medication/health products with which you have had a reaction and what type of reaction occurred).

____

____

____

Medications (List all medication names including non-prescription medications, vitamins, herbs or supplements) Please include the dosage, and how many you take daily (example: Lasix 20mg 1 tablet)

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.
11.	12.

Past Medical History

Do you have any diagnosed medical conditions? (Circle one) YES NO

If yes, please check the box next to the condition and write the year diagnosed

Condition/Disease	✓	**Year**	**Condition/Disease**	✓	**Year**
Acid Reflux/Ulcers			Heart Disease/Heart Attack		
Alcoholism/Cirrhosis			Hepatitis/Jaundice		
Anemia			High Blood Pressure		
Anxiety/Depression			Lung Disease		
Arthritis			Prostate Disease		
Asthma/COPD			Seizures/Epilepsy		
Blood Disorder/Clots			STDs: chlamydia, genital warts, gonorrhea, herpes, HIV, HPV, syphilis, trichomoniasis		
Bone or Spine Disorder			Stroke		
Cancer			Thyroid Disease		
Cataracts			Tuberculosis		
Diabetes			Other Mental Illness		
Glaucoma			Other (please describe)		
Crohn's/Colitis					

Have you ever had a stress test or calcium score for detecting heart disease? YES NO

If yes, when? ___________

Please list any specialists you have seen in the last 5 years: ____
____
____

(Please list all hospitalizations and surgeries with an approximate date)

Hospitalizations and/or Surgeries	Date	Hospitalizations and/or Surgeries	Date

Date of last colonoscopy: _____________
Date of last DEXA bone density scan: ___________

Immunizations
Date of last flu immunization: ______________
Date of last tetanus (Tdap) immunization: _______________
Date of last shingles immunization: _______________
Date of last pneumonia immunization: ______________

Family History: (Please check the appropriate boxes: living or not living, and any illness that applies)

	Living	Not Living	Diabetes	High Blood Pressure	Heart Disease	Strok e	Cancer (type)	Mental Illness	Other
Mother									
Father									
Maternal Grandmother									
Maternal Grandfather									
Paternal Grandmother									
Paternal Grandfather									
Siblings									
Children									

Male children: ______, Ages: ______________. # Female children: _______, Ages: __________________.
Are your children healthy? YES NO
If NO, please explain: ____

Social History

1. Marital status (circle one): Married / Single / Separated / Divorced / Widowed/ Coupled
2. Sexual orientation (circle one): Heterosexual / Homosexual / Bisexual
3. Do you live alone? YES NO
4. What is your occupation: ___________________________
5. Number of caffeinated beverages you drink per day: _____________
6. Do you use tobacco products? YES NO What type? (circle one): Cigarettes Chew Cigars Pipe
   If Cigarettes, # packs per day? ________
   How many years? ________
   Have you stopped? YES NO When? __________
7. Do you drink alcohol? YES NO How many drinks/week? _______ Type? Wine/Beer/Liquor
8. Do you use recreational/street drugs? YES NO
   What do you use and how often? __________________________
9. Have you ever had a DUI? YES NO
   If yes, when? ___________

10. Please fill out the following 2 tables

Question:	**YES**	**NO**
C: Have you ever felt that you should **C**ut down your drinking?	1	0
A: Have people **A**nnoyed you by criticizing your drinking?	1	0
G: Have you ever felt **G**uilty about your drinking?	1	0
E: Have you ever had a drink first thing in the morning (**E**ye opener)	1	0

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
1. Little to no interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**

Female Patients Only

1. Date of last period: ___________
2. Date of last PAP/pelvic exam: ___________
3. Are you currently pregnant? YES NO
4. Number of pregnancies: ___________ Number of children: __________
5. Are you currently taking birth control pills or other hormones? YES NO
   Name of medication: ________________________________
6. What do you currently use for birth control? ______________________
7. Have you gone through menopause? YES NO If yes, at what age? _________
8. Date of last mammogram: __________