NEW PATIENT QUESTIONNAIRE

Name: _____ Date of Birth: ____/____/_____

***PLEASE COMPLETE THE QUESTIONS BELOW:**

1) **TOBACCO USAGE: Check circles if they apply**
   - ○ **Never Used**
   - ○ **Quit Year Quit: _____**
   - ○ **Current Every Day User**
   - ○ **Current Some Day User**
     Packs Per day:____ How Many Years Used:_____
     What did you use: _____
   - ○ **Passive Smoke (around other smokers)**
   - ○ **Smokeless Tobacco Products**

2) **CAFFINE USAGE:**
   - ○ **Do you consume caffeinated beverages?**
     Yes/No
     If yes, how many drinks per day? _____
     Time of day?_____

3) **FAMILY HISTORY:**
   - ○ **Heart Attacks in females under the age of 65?**
     Yes/No
   - ○ **Heart Attacks in males under the age of 55?**
     Yes/No

4) **ALCOHOL USAGE:**
   - **Drink Alcohol Daily?**

     Yes/No

     If yes:
     - **Do you drink daily, weekly, or monthly?**
     - **How Many Drinks? _____**
     - **Type of Alcohol? _____**
     - **Been annoyed by complaints of your drinking?**

       Yes/No
     - **Felt Guilty about your drinking?**

       Yes/No
     - **Need an "eye opener" in the morning?**

       Yes/No

5) **EXERCISE:**
   - **Do you exercise?**

     Yes/No

     If yes:
     - **What type? _____**
     - **Frequency? _____**
     - **Duration? _____**

ADULT MEDICAL HISTORY FORM

NAME: _____ DATE: ____/_____/_____

1) **Reason for visit today? _____**
2) **Please list your current medical problems:**

   _____

   _____

   _____

3) **Circle any of these conditions you have had:**

   Anemia Addictions Asthma Diabetes Eating Disorder

   Heart Disease HIV Hypertension Kidney Disease

   Kidney Stones Migraines Psychological Problems

4) **List all surgeries with date done (month/year) if known:**

   _____

   _____

   _____

   _____

5) **List all current medications and dosage: Include over the counter**

   (Please disregard if you have your medications with you today)

   _____ _____

   _____ _____

   _____ _____

   _____ _____

6) **List all allergies and reactions:**

   _____ _____

   _____ _____

   _____ _____

   _____ _____

7) **List of any family medical history: i.e. High blood pressure, Heart Disease, Stroke, Diabetes, Cancer (with type of cancer)**

   - **Father_____**
   - **Mother_____**

- **Siblings_____**
- **Grandparents_____**

8) Social History:

- **Marital Status:_____**
- **Number of children:_____**
- **Occupation:_____**
- **Religious Preference:_____**

9) Health Maintenance Values:

- **Last Physical Exam:_____**
- **Colon Cancer Screening: Colonoscopy_____ Cologuard_____**
- **Last Pap Smear Date:_____ N/A Hysterectomy_____**
- **Last Mammogram Date:_____**
- **Last Bone Density Date: _____**
- **Last Eye Exam: _____**
- **Last Dental Exam: _____ N/A Dentures _____**

10) Vaccines (month/year):

- **Last Influenza Vaccine: _____**
- **Pneumonia Vaccines:**
  Prevnar 13_____ Pneumovax 23_____
- **Shingles Vaccine:**
  Zostavax _____ Shingrix_____
- **TDAP or Tetanus _____**

11) Diagnostic Tests:

- **EKG: _____**
- **Echocardiogram:_____**
- **Cardiovascular Stresss Test: _____**
- **Endoscopy: _____**

12) Labs:

- **Last Cholesterol check:_____**
- **Hgb A1c (Diabetic & Prediabetic pts):_____**