**Adult New Patient Questionnaire**

Spouse/Partner Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children(s): Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who was your last PCP? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your current OB/GYN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Please list any specialists you see regularly: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When were your most recent health maintenance screening tests?**

Colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: Normal Abnormal Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eye Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: Normal Abnormal Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: Normal Abnormal Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pap Smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: Normal Abnormal Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Tdap Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: Normal Abnormal Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any drug allergies? If so please list the medication and the reaction that occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Illnesses or Medical Problems Past & Present (Ex: heart disease, hypertension, seasonal allergies)** | **Date of Onset** |
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| **Operations or Injuries** |  |
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| **Current Medications (include over the counters, supplements, herbals, etc)** | **Dosage** |
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**Please check each box that applies:**

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| --- | --- | --- | --- | --- | --- |
|  | Mother | Father | Grandparent | Sibling | Child |
| Heart Attack |  |  |  |  |  |
| Stroke |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |
| Diabetes |  |  |  |  |  |
| Asthma or Breathing Problems |  |  |  |  |  |
| Seizures or Epilepsy |  |  |  |  |  |
| Mental Illness (Depression, Anxiety, ADHD) |  |  |  |  |  |
| Birth Defects |  |  |  |  |  |
| Alcoholism |  |  |  |  |  |
| Bleeding or Clotting Problems |  |  |  |  |  |
| Cancer |  |  |  |  |  |

Other (Please list condition and family member affected):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you smoke cigarettes or use a vape pen? Never Sometimes Current Smoker Quit

Number of packs per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of years smoked: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
If you were a previous smoker, what was your quit date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do you use any other type of tobacco: Pipe Cigar Snuff Chew

Are you interested in quitting? Yes No

Do you drink alcohol? Yes No

Number of drinks per day: \_\_\_\_\_\_\_\_ week: \_\_\_\_\_\_\_\_ month: \_\_\_\_\_\_\_\_

Type of alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your alcohol use a concern for yourself or others? Yes No

Do you use any recreational drugs? Yes No

Have you EVER used needles? Yes No

(This information is used strictly for medical purposes and is not reported to law enforcement.)