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 (M / F)	Birth Date	Today's Date

Street Address	City	State	Zip	Social Security Number

Home Phone	Mobile Phone	Email Address

Primary Language	Do you need an interpreter? (Yes / No)	Race *(optional)*	Ethnicity *(optional)*	Religion *(optional)*

Marital Status	Name of Partner or Spouse	Do you live alone? (Yes / No)	Number of Members in Your Household

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

If you are under the age of 18, please complete the following section.

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 *List the most recent date for each of the following:*			
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 *Check ☑ conditions you have or have had in the past.*			
❑ Alcoholism	❑ Chemical dependence	❑ Hepatitis	❑ Psychiatric care
❑ Anemia	❑ Depression	❑ Herpes	❑ Rheumatic fever
❑ Anxiety	❑ Diabetes	❑ High blood pressure	❑ Seasonal allergies
❑ Arthritis	❑ Eating disorder	❑ High cholesterol	❑ Sexual difficulty
❑ Asthma	❑ Emphysema/COPD	❑ HIV/AIDS	❑ Sexually transmitted infection
❑ Autoimmune disease	❑ Epilepsy/Seizures	❑ Kidney disease	❑ Skin rash
❑ Bleeding/Clotting disorder	❑ Erectile dysfunction	❑ Liver disease	❑ Sleep apnea
❑ Bone/Joint disorder	❑ GERD (reflux)	❑ Multiple sclerosis	❑ Stroke
❑ Breast lump	❑ Goiter	❑ Osteoporosis	❑ Thyroid problem
❑ Cancer *(see below)*	❑ Gout	❑ Peripheral vascular disease	❑ Tuberculosis
❑ Congestive heart failure	❑ Headaches	❑ PPD positive	❑ Urinary incontinence
❑ CAD/Heart disease	❑ Heart attack	❑ Prostate problem	❑ Vaginal infection
❑ 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:
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____________

SURGICAL HISTORY		
YEAR	LOCATION	TYPE *(Please describe any complications)*

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

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

During the past month, have you felt down, depressed, or hopeless?	❑ Yes ❑ No
During the past month, have you felt little interest or pleasure in doing things?	❑ Yes ❑ No

Patient Name______________________________________ Date of Birth___________ Today's Date___________

MEDICATIONS	***List all medications, including over-the-counter medications and supplements. Write dosage and frequency for each medication.***

**Please attach additional sheets if necessary.*

ALLERGIES	
❑ No Known Allergies	❑ Yes, I have the following medication and/or food allergies. Please describe your reaction to each medication/food listed.

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

Check ☑ if a blood relative has had any of the following. List relationship of relative to you.	
❑ Alcoholism/Substance abuse:	❑ High cholesterol:
❑ Autoimmune disorder:	❑ Kidney disease:
❑ Asthma:	❑ Mental illness:
❑ Bleeding/Clotting disorder:	❑ Osteoporosis:
❑ Cancer:	❑ Stroke:
❑ Diabetes:	❑ Thyroid problem:
❑ Heart disease:	❑ Other:
❑ 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**