"The Practice" LLC
Family Medicine

NEW PATIENT HEALTH QUESTIONNAIRE

Name _____ Date _____

DOB: _____ Age: _____ New Patient _____ Established _____

PLEASE NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

What medical concerns bring you to our office? _____

Marital Status *(circle)* **S M D W** Occupation *(if retired, previous occupation)* _____

If disabled, check here ____ Nature of disability _____ Birthplace _____

Do you exercise regularly? *(circle)* No Yes If *Yes,* what exercise/how often? _____

Have you ever smoked? *(circle)* No Yes Cigar Pipe Cigarettes If Yes: #cigarettes/day _____ #yrs. _____

If you have never smoke, skip this question. Do you still smoke now? *(circle)* No Yes If *No,* when did you quit? _____

Do you have completed Advanced Directives or do you have a Live Will *(circle)* No Yes Which _____

Caffeine: Do you drink? *(circle)* caffeinated coffee, teas or sodas regularly? *(circle)* No Yes #/day _____

Tell us a little about your home environment: *(e.g. live alone, with family, single parent, house, apt., etc.)*

_____

Are you under a lot of pressure at work or at home? *(circle)* No Yes Home Work Both

MEDICAL INFORMATION

Allergies: Are you allergic to any drugs? *(circle)* No Yes Please list _____

Medications *(list all medications you are taking regularly. Include over the counter, herbal or natural remedies)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medical Illnesses or **Conditions** *(list any chronic conditions which you have been diagnosed to have)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you ever had or been diagnosed to have: *(check box by all that apply)*

Cataracts		Heart Disease		Ulcers		Anemia		Depression	
Glaucoma		Heart Murmur		Digestive Disorder		Bleeding Disorders		Frequent Infection	
Asthma		High Blood Pressure		Hemorrhoids		Bone or Joint Disease		Cancer *(type)*	
Allergies		Pneumonia		Kidney Disease		German Measles		High Cholesterol	
Stroke		TB/Lung Disease		Kidney Stone(s)		Rheumatic Fever		Prostate Enlargement	
Seizures/Epilepsy		Pleurisy		Diabetes or PreDiabetes		Chicken Pox			
Heart Attack or Angina		Jaundice or Liver Disease		Thyroid Disease		Syphilis			

Operations:
Please list any surgery and approximate year

Year **Surgery**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Hospitalizations:
Other than operations

Year **Reason** **Hospital**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

FAMILY HISTORY	**Age**	**Health** *(list significant illnesses)*	**Age At Death**	**If deceased, cause**	**Comments**
Father					
Mother					
Brothers/Sisters:					
Spouse					
Children					

Has any blood relative ever had? *(check if Yes and indicate relationship to you)*

____ Alzheimer's_____ ____ Heart Attack before age 55 _____ ____ Alcoholism _____
____ Tuberculosis_____ ____ Bleeding Disease _____ ____ Mental Disorder_____
____ Diabetes _____ ____ Stroke _____ ____ Allergies _____
____ High Blood Pressure _____ ____ Seizures _____ ____ Asthma _____
____ Heart Disease _____ ____ Depression/Suicide _____ ____ Cancer _____

Immunizations *(check if Yes and indicate year of last injection)*

____ Influenza _____ ____ Pneumonia _____ ____ MMR _____
____ Influenza _____ ____ Influenza _____ ____ Other _____

Transfusions: Have you ever had a blood or plasma transfusion *(circle)* No Yes

Weight: What is your weight now? _____ One year ago? _____ Maximum? _____ When? _____

Females Only: Are you pregnant, planning a pregnancy or nursing a child? *(circle)* No Yes

Date of last menstrual period? _____

The Practice Family Medicine New Patient Questionnaire Part 2

Name: _____ DOB/ID: _____

Please indicate those items that have been a recurrent or recent significant change

Yes	No	**Constitutional Symptoms**
___	___	Good health lately
___	___	Recent significant weight change
___	___	Unusual fatigue or weakness
___	___	Frequent headaches
		Eyes
___	___	Change in vision
___	___	Blurred or double vision
___	___	Eye disease or injury
___	___	Wear glasses/contact lenses?
		Ear/Nose/Mouth/Throat/Neck
___	___	Do you wear hearing aids?
___	___	Hearing loss or ringing in the ears?
___	___	Earaches or drainage?
___	___	Chronic sinus problems or runny nose
___	___	Nose bleeds
___	___	Mouth sores
___	___	Bleeding gums
___	___	Sore throat/hoarseness or voice change
___	___	Lumps or swollen glands in neck
___	___	Difficulty swallowing
___	___	Neck pain or stiffness
		Cardiovascular
___	___	Heart trouble
___	___	Chest pain or angina pectoris
___	___	Palpitations
___	___	Shortness of breath with walking or lying flat
___	___	Swelling feet, ankles or hands
___	___	Waking at night with shortness of breath
		Respiratory
___	___	Chronic or frequent cough
___	___	Coughing or spitting up blood
___	___	Shortness of breath
___	___	Asthma or recurrent wheezing
		Gastrointestinal
___	___	Loss of appetite
___	___	Change in bowel movements
___	___	Nausea or vomiting
___	___	Painful bowel movements or constipation
___	___	Frequent diarrhea
___	___	Rectal bleeding or blood in stool
___	___	Stomach/adnominal pains or heartburn
___	___	Black or tarry stools

Comments _____

_____

_____

Yes	No	Genitourinary
___	___	Frequent Urination
___	___	Burning or pain or urination
___	___	Blood in urine
___	___	Change in force or strain when urinating
___	___	Incontinence or dribbling of urine
___	___	Sexual difficulties
___	___	Men: Testicular pain
___	___	Women: Painful periods
___	___	Irregular periods
___	___	Recurrent vaginal discharge

Number of pregnancies (including miscarriages) _____

_____ #Deliveries _____ #Miscarriages

Method of birth control (if applicable) _____

Menopausal, since when: _____

Date of last menstrual period _____

Date of last pap smear _____

Date of last mammogram _____

Yes	No	**Musculoskeletal**
___	___	Joint pain(s)
___	___	Joint stiffness/swelling or warmth
___	___	Weakness of muscles or joints
___	___	Muscle pain or recurrent cramps
___	___	Back pain
___	____	Cold hands or feet
___	___	Difficulty in walking
		Integumentary (Skin/Breast)
___	___	Rashes or itching
___	___	Change in skin color or moles
___	___	Change in hair or nails
___	___	Varicose veins
___	___	Breast Pain
___	___	Breast lump
		Neurological
___	___	Varicose veins
___	___	Frequent, recurring or increasing headaches
___	___	Light-headedness or dizziness
___	___	Convulsions, seizures or spasms
___	___	Numbness or tingling sensations
___	___	Tremors
___	___	Paralysis
___	___	Stroke
___	___	Head Injury

Please complete other side of form

Yes	No	Psychiatric
___	___	Memory loss or confusion
___	___	Nervousness
___	___	Insomnia
___	___	Depression
		Endocrine
___	___	Glandular or hormone problem
___	___	Heat or cold intolerance
___	___	Excessive skin dryness
___	___	Excessive thirst or urination
___	___	Change in hand or glove size
		Hematologic/Lymphatic
___	___	Slow to heal after cuts or wounds
___	___	Bleeding or bruising tendency
___	___	Recurrent anemia
___	___	Swelling, warmth or tenderness of veins or history of phlebitis

Yes	No	Allergic/Immunologic
___	___	History of skin reaction or other adverse reaction to: _____
___	___	Penicillin or other antibiotic: Describe reaction: _____
___	___	Morphine, Demerol or other narcotics reaction: _____
___	___	Novocain or other anesthetics reaction: _____
___	___	Aspirin or other pain remedies reaction: _____
___	___	Tetanus antitoxin or other serums _____
___	___	Iodine, merthiolate or other antiseptic
___	___	Other medications: _____
___	___	Other known food allergies: _____

Comments: _____

_____

_____

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_____

_____

Patient Signature: _____ **Reviewed by:** _____

Date: _____ **Date:** _____

Hx: _____

_____

_____

_____

_____

_____

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_____

_____

Physician Signature: _____ **Date:** _____