NEW PATIENT MEDICAL QUESTIONNARE

Patient Name: ________________________________DOB: _______________ DATE:______________

PHARMACY INFORMATION

Preferred Pharmacy	Secondary Pharmacy
Name: ______________________________________	Name: ______________________________________
Address: ____________________________________	Address: ____________________________________
Phone: _________________ Fax: ________________	Phone: _________________ Fax:________________

ADVANCED DIRECTIVES

□ None □ Do Not Resuscitate □ Durable Power of Attorney □ Living Will □ HC Proxy Reviewed: ______

MEDICATIONS- List ALL medications you take, prescription and non-prescription, and the dosage

□ I do not take any medications

Medication Name	Dosage
______________________________________	______________________________________
______________________________________	______________________________________
______________________________________	______________________________________
______________________________________	______________________________________
______________________________________	______________________________________
______________________________________	______________________________________

MEDICATION AND FOOD ALLERGIES- List ALL known allergies (drug, food, animals, environmental, etc.)

□ I have no known allergies

______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________

WOMEN'S REPRODUCTIVE HISTORY

Age of first period: _____ # of Pregnancies: _____ # of Miscarriages: _____ # of Abortions: _____

Have you reached menopause? □ YES □ NO
At what age? _______

Do you have regular periods? □ YES □ NO
LMP: ________

MEDICAL HISTORY- Check if you have ever experienced the following conditions and specify year of onset.

Condition	Year	Condition	Year
□ NONE	______________	□ Gallbladder Disease	________________
□ Allergies	______________	□ GERD (Reflux)	________________
□ Anemia	______________	□ Hepatitis C	________________
□ Angina	______________	□ Hyperlipidemia	________________
□ Anxiety	______________	□ Hypertension	________________
□ Arthritis	______________	□ Irritable Bowel Disease	________________
□ Asthma	______________	□ Liver Disease	________________
□ Atrial Fibrillation	______________	□ Migraine Headaches	________________
□ Benign Prostatic Hypertrophy	______________	□ Myocardial Infarction	________________
□ Blood Clots	______________	□ Osteoarthritis	________________
□ Cancer- Type _______________	______________	□ Osteoporosis	________________
□ Cerebrovascular Accident (CVA)	______________	□ Peptic Ulcer Disease	________________
□ Coronary Artery Disease (CAD)	______________	□ Renal Disease	________________
□ COPD (Emphysema)	______________	□ Seizure Disorder	________________
□ Crohn's Disease	______________	□ Thyroid Disease	________________
□ Depression	______________	□ Other ____________________	________________
□ Diabetes	______________	□ Other ____________________	________________

SURGICAL HISTORY- Check if you have received the following procedures and specify year performed

□ NONE

Surgical Procedure	Year	Surgical Procedure	Year
□ Angioplasty	______________	MALE ONLY	
□ Angioplasty with Stent	______________	□ Prostate Biopsy	______________
□ Appendectomy	______________	□ TURP	______________
□ Arthroscopy Knee	______________	(Trans-Urethral Resection of Prostate)	
□ Back Surgery	______________	□ Vasectomy	______________
□ CABG (heart bypass)	______________	□ Other ____________________	______________
□ Carpal Tunnel Release	______________	□ Other ____________________	______________
□ Cataract Extraction	______________	FEMALE	
□ Cholecystectomy	______________	□ Augmentation Mammoplasty	___________
□ Colectomy	______________	□ Bilateral Tubal Ligation	___________
□ Colostomy	______________	□ Breast Biopsy	___________
□ Gastric Bypass	______________	□ Cesarean Section	___________
□ Hernia Repair	______________	□ D and C	___________
□ Hip Replacement	______________	□ Hysterectomy	___________
□ Knee Replacement	______________	□ Mastectomy	___________
□ LASIK	______________	□ Myomectomy	____________
□ Liver Biopsy	______________	□ Reduction Mammoplasty	____________
□ Pacemaker	______________	□ TAH/BSO	____________
□ Small Bowel Resection	_______________	□ Vaginal Hysterectomy	____________
□ Thyroidectomy	_______________	□ Other ________________________	
□ Tonsillectomy	_______________	□ Other _________________________	

HEALTH MAINTENANCE- Check if you have received the following and specify date of most recent exam.

Exam	Year	Exam	Year
□ Breast Exam	_____________	□ GYN Exam	_____________
□ Cardiac Stress Test	_____________	□ Influenza Vaccine	_____________
□ Colonoscopy	_____________	□ Lipid Panel	_____________
□ DEXA Exam	_____________	□ Mammogram	_____________
□ Echocardiogram	_____________	□ Pap Test	_____________
□ EKG	_____________	□ Physical Exam	_____________
□ Eye Exam	_____________	□ Pneumococcal Vaccine	_____________
□ FOBT	_____________	□ Pulmonary Function Test	_____________
(stool card for hidden blood)		□ Sigmoidoscopy	_____________
□ Foot Exam	_____________	□ Tetanus Vaccine	_____________

□ NONE (check here if none have been done)

FAMILY HISTORY- Check if any family member(s) has had any of the following conditions.

Diagnosis	Father	Mother	Brother	Sister	Other	Other	Other
□ Alcoholism	□	□	□	□	□	□	□
□ Allergies	□	□	□	□	□	□	□
□ Alzheimer's Disease	□	□	□	□	□	□	□
□ Asthma	□	□	□	□	□	□	□
□ Blood Disease	□	□	□	□	□	□	□
□ CAD (Heart Attack)	□	□	□	□	□	□	□
□ Cancer- TYPE	□	□	□	□	□	□	□
□ CVA (Stroke)	□	□	□	□	□	□	□
□ Depression	□	□	□	□	□	□	□
□ Developmental Delay	□	□	□	□	□	□	□
□ Diabetes	□	□	□	□	□	□	□

□ Adopted/ I don't know my family history

OTHER HEALTH ISSUES

TOBACCO USE: Smoke Cigarettes? □ YES □NO If yes, How many packs per day: _____ # of years _____
Past: Quit Date: _________ Packs/day _______ # of Years _______ Other Tobacco □ Pipe □ Cigar □ Snuff □ Chew

ALCOHOL/DRUG USE:
Do you drink alcohol? □ YES □ NO # of Drinks per day/week: _________
Do you use marijuana or recreational drugs? □ YES □ NO Notes: ________________________________
Have you ever sued needles to inject drugs? □ YES □ NO Notes: ________________________________
Have you ever taken someone else's drugs? □ YES □ NO Notes: ________________________________

OTHER HEALTH ISSUES (CONTINUED)

SEXUAL ACTIVITY: Are you sexually active? □ YES □ NO (If no sexual history, please continue to the next page)
Sexual partner(s) is/are/have been: □ MALE □ FEMALE □ BOTH
Birth Control Method: □ NONE □ Condoms □ Pill/Ring/Patch/Injections/IUD □Vasectomy □ Other: ___________

EXERCISE: Do you exercise regularly? □ YES □ NO What kind of exercise? ________________ Duration? (how long):

_________ How often: _______________

SLEEP: How many hours, on average, do you sleep each day? ________
DIET: How would you rate your diet? □ GOOD □ FAIR □ POOR Would you like education or information on how to improve your health through your diet? □ YES □ NO
SAFETY: Do you use a bike helmet? □ YES □NO □N/A Do you use seat belts consistently? □ YES □ NO
If you have guns at home □ NO □ Yes, are they locked up? ______________
Working smoke detector in home? □ YES □ NO
Is violence at home a concern for you? □ YES □ NO Notes: ____
____

OTHER PROVIDERS AND/OR SPECIALISTS

Specialist	Name	Last Visit (MM/YY)
Cardiology	________________________	____________________
Gastroenterologist	________________________	____________________
OB/GYN	________________________	____________________
Neurology	________________________	____________________
Pulmonary	________________________	____________________
Other: _______________	________________________	____________________
Other: _______________	________________________	____________________
Other: _______________	________________________	____________________

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? □ YES □ NO If yes, where? ___________________

Have you served in the military? □ YES □ NO If yes, how long and what branch? __________________________
Were you deployed? □ YES □ NO If yes, where?

Other medical concerns or conditions to discuss:
____
____

Patient Name: ___________________ Patient Signature: ______________________ Date:_______________