New Patient Questionnaire for Primary Care

Name: _____ DOB: _____

Address: _____

Home phone: _____ Cell phone: _____

Reason for visit: _____

Primary Care Physician you are currently using and their phone number:

_____

Other health care providers, such as specialists:

Specialty	Name	Phone	Date last seen
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

Medical	Reaction	Food	Reaction	Environmental	Reaction

Health Screenings (most recent)

	Where	Year	Normal		Explain
Bone Density test			Yes	No	
Cholesterol level			Yes	No	
Colonoscopy			Yes	No	
Diabetes test			Yes	No	
Prostate check			Yes	No	
Eye exam			Yes	No	
Mammogram			Yes	No	
Pap Smear			Yes	No	

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Immunizations

Type	Yes	No	Year
TD			
TDAP			
MMR			
Pneumonia			
Hepatitis A			
Hepatitis B			
Shingles			
Prevnar			
Flu			

Please list the medications you are currently taking

Medication name	Dose	Units (mg)	How often	Start date	End date
Example: Men's multivitamin (brand name)	1200	Mg	Daily	02/20/2014	Current

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Do you want medications from the VA? **Yes _____ No _____**

Medical History: *(check if you have ever had or been diagnosed with any of the following)*

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis (rheumatoid)
- ☐ Arthritis (osteo.)
- ☐ Bipolar
- ☐ Cancer - _____
- ☐ Constipation
- ☐ Chronic Lung Disease
- ☐ Deep Venous Thrombosis
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Fibrocystic Breast Disease
- ☐ Fibromyalgia
- ☐ Gallstones
- ☐ Hard of Hearing
- ☐ Heart-Mitral Valve Prolapse
- ☐ Heart murmur
- ☐ Heart-Coronary Artery Disease
- ☐ Herpes, Genital
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Infertility
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Mental Illness
- ☐ Migraine Headaches
- ☐ Ovarian Cysts
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Sickle Cell Anemia
- ☐ Sickle Cell Trait
- ☐ Stroke
- ☐ Transfusions
- ☐ Tuberculosis
- ☐ Ulcer (Stomach)
- ☐ Urinary Incontinence
- ☐ STD
- ☐ Vision Problems

Social History

Marital Status:

- ☐ Married
- ☐ Divorced/Separated
- ☐ Single
- ☐ Widow/Widower

Are you sexually active?

- ☐ Yes
- ☐ No

Education:

Grade completed _____

- ☐ GED
- ☐ Graduated High School
- ☐ Some College
- ☐ Graduated College – 2 year
- ☐ Graduated College – 4 year
- ☐ Post-graduate _____

New Patient Questionnaire for Primary Care

Social History (continued)

Alcohol Use:
- ☐ Never
- ☐ Current
- ☐ Former

Amount used _____
Date started _____
Date stopped _____

Tobacco Use:
- ☐ Never
- ☐ Current
- ☐ Former

Amount used _____
Date started _____
Date stopped _____

Recreational Drug Use:
- ☐ Never
- ☐ Current
- ☐ Former

Type used _____
Date started _____
Date stopped _____

Occupation _____

Hazard Exposure
- ☐ Yes
- ☐ No

If yes, describe exposure _____

Do you exercise regularly?
- ☐ Yes
- ☐ No
- ☐ What do you do? _____

Have you been a victim of Domestic/Sexual Violence?
- ☐ Yes
- ☐ No

Travel History

Do you use your seat belt?
- ☐ Yes
- ☐ No

Any recent travel?_____

Any travel related illnesses? _____

Military History

What branch of the Armed Forces and the dates did you serve?

_____

_____

Family Medical History

Father: _____ Mother: _____

Sibblings:_____