HEALTHY LIVING PRIMARY CARE

Name _____ Date of Birth _____

Comprehensive New Patient Health History Questionnaire

Main reason for today's visit: _____

Please list all healthcare providers you see regularly: _____

_____

PERSONAL MEDICAL HISTORY: Have you ever had any of the following conditions?

□ **Check box if you have no history of significant medical illnesses.**

Condition	*Now*	*Past*
Alcohol / Drug abuse		
Allergy (Hay Fever) (_____)		
Anemia		
Anxiety		
Arthritis (Rheumatoid)		
Arthritis (Osteoarthritis)		
Asthma		
Bladder / Kidney Problems		
Blood Clot (_____)		
Cancer (_____)		
Cataracts		
Chronic Pain (_____)		
Colon Polyp		
Coronary Artery Disease		
Depression		
Diabetes (adult onset)		
Diabetes (childhood onset)		
Diverticulosis		
Emphysema (COPD)		
Fractures (broken bones)		
Gallbladder Disease		
Gastroesophageal Reflux (Heartburn/GERD)		
Glaucoma		
Gout		

Condition	*Now*	*Past*
Gynecological Conditions (Endometriosis)		
Gynecological Conditions (Fibroids)		
Gynecological Conditions (Other)		
Hepatitis – Type A | B | C		
Herpes (cold sore or genital)		
High Blood Pressure		
High Cholesterol		
Inflammatory Bowel Disease		
Irritable Bowel Syndrome		
Kidney Disease / Failure		
Kidney Stones		
Liver Disease		
Migraine Headaches		
Osteoporosis		
Prostate (enlargement)		
Seizure / Epilepsy		
Sleep Apnea		
Stomach Ulcer		
Stroke		
Thyroid (Nodule)		
Thyroid High (Overactive) / Hyperthyroidism		
Thyroid Low (Underactive) / Hypothyroidism		
Other (_____)		
Other (_____)		

SURGICAL & PROCEDURE HISTORY – Please enter the year of any procedures or surgeries below.

□ **Check box if you have never had any medical procedures or surgeries.**

Surgical Procedure	*Year*
Abdominal surgery (_____)	
Appendectomy (appendix removal)	
Back surgery	
Biopsy (_____)	
Breast Biopsy	
Breast surgery	
Cataract surgery	
Coronary Bypass	
Coronary Stent	
C-Section	
Gallbladder Removal	
Heart Surgery(_____)	
Hip Surgery (_____)	

Surgical Procedure	*Year*
Hysterectomy (partial, ovaries left)	
Hysterectomy (total, including ovaries)	
Joint Arthroscopy (_____)	
LEEP (Cervix surgery)	
Neck Surgery	
Ovary Removal	
Sinus Surgery	
Tonsillectomy	
Tubal ligation	
Urological Surgery	
Vascular Surgery (_____)	
Vasectomy	
Other (_____)	

Please go to next page

FAMILY HISTORY

Adopted? □ No □ Yes. If adopted, and you do not know your family history, skip the Family History section.

Indicate which relative has had the following diseases (parents, brothers & sisters are the most important). Write in number of siblings in appropriate boxes.* If some siblings are alive and some are deceased use the space to the right to explain further.

	Mother	*Father*	** Sister(s)*	** Brother(s)*	*Mom's Mom*	*Mom's Dad*	*Dad's Mom*	*Dad's Dad*	
Alive									
Deceased									
Age currently or at death									
Diseases & Conditions	***Mother***	***Father***	***Sister(s)***	***Brother(s)***	***Mom's Mom***	***Mom's Dad***	***Dad's Mom***	***Dad's Dad***	***Other blood relatives (list relationship to you)***
No significant history known									
Hypertension – high blood pressure									
Hyperlipidemia – high cholesterol									
Heart Attack, Angina (Coronary Artery)									
Diabetes Type I (childhood onset)									
Diabetes Type II (adult onset)									
Osteoporosis									
Depression									
Alcoholism / Drug abuse									
Alzheimers									
Asthma									
Autoimmune Disease									
Bleeding or Clotting Disorder									
Cancer (_____)									
Colon Polyp									
Emphysema (COPD)									
Genetic Disorder (explain)									
Heart Disease (CHF)									
Hepatitis B or C									
Hypothyroidism / Thyroid Disease									
Kidney Disease									
Stroke									
Sudden Cardiac Death									
Other (_____)									
Other (_____)									

MEDICATIONS: Please list (or show us your own printed record) **all** prescription and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc).

□ Check box if you do not take any prescription or over the counter medications.

□ Check box if you brought a list of your medications (give it to my assistant and don't write in medications below).

ALLERGIES or intolerance to medications? □ No known drug allergies

(If yes, to what & what reaction?) _____

Medication	Dose (e.g. mg/pill)	How often?	Medication	Dose (e.g. mg/pill)	How often?

Please go to next page

IMMUNIZATIONS: □ Voluntarily declined all vaccines

Vaccine	Date
Hepatitis A	
Hepatitis B	
HPV	
Influenza (flu shot)	

Vaccine	Date
Pneumovax (Pneumonia)	
Prevnar 13 (Pneumonia)	
Tetanus (Td)	
Varicella (Chicken Pox)	

Vaccine	Date
Whooping Cough (DTaP)	
Zostavax (shingles)	

HEALTH MAINTENANCE SCREENING TESTS:

Test	Date	Result
Screening Labs		□ Normal □ Abnormal
Physical Exam		□ Normal □ Abnormal
Endoscopy		□ Normal □ Abnormal
Women Only		
Mammogram		□ Normal □ Abnormal
Pap Smear		□ Normal □ Abnormal

Test	Date	Result
Sigmoidoscopy		□ Normal □ Abnormal
Colonoscopy		□ Normal □ Abnormal
Stress Test		□ Normal □ Abnormal
Bone Density Test (DEXA)		□ Normal □ Abnormal

HEALTH ISSUES:

Tobacco Use

Exposure to second hand smoke? □ Yes □ No

Smoke / smoked □ Cigarettes □ E-Cigarettes □ Pipe □ Cigar □ None

□ **Never Smoked**

□ **Current smoker:** Packs/day: _____ # of years: _____

Are you ready to quit? □ No □ Yes

□ **Former smoker:** Quit date: _____

Approximately how many packs/day did you smoke? ____

How many years did you smoke? ____

Alcohol Use

Do you drink alcohol? □ No □ Yes

# of drinks/week:_____ □ Beer □ Wine □ Liquor

How many times in a year have you had >3 drinks (for women) or >4 drinks (for men) in a day? _____

Drug Use

Have you **ever** used recreational drugs? □ No □ Yes

If yes, which ones? _____

Quit which ones? □ All _____

Any used currently? _____

SOCIAL HISTORY:

Marital status: □ single □ partner □ married □ divorced □ widowed Spouse/partner's name: _____

Number of children:_____ Age and sex of your children:_____ # of grandchildren: ____ # of great grandchildren: ____

Education: □ high school or GED □ trade school □ college □ graduate school □ other _____

Occupation: _____ Employer:_____

If you are not working, you are: □ retired □ unemployed □ on a leave of absence □ disabled □ homemaker □ other _____

Country of birth: _____

WOMEN'S HEALTH HISTORY:

Total number of pregnancies:_____ Number of births:_____ Number of miscarriages:_____Number of abortions:_____

Thank you for taking the time to complete this form