Name Date

# Comprehensive Adult New Patient Health History Questionnaire

Your answers on this form will help us get an accurate history of your medical concerns and conditions. Please fill in all **six** pages. It is long because it is comprehensive. We really want to know you well so we can properly care for you. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank-you!

**Who referred you to my practice?**

**Circle one: patient, family member, physician, assigned. Name?** _____

**Main reason for today's visit:** _____

**Other concerns:** _____

_____

**What are your health goals for the next year?** _____

**How would you rate your health? (circle one): Excellent / Good / Fair / Poor**

**Please list healthcare providers & their specialty you see regularly:** _____

_____

**List any medical suppliers you use (e.g. respiratory supplies, etc):** _____

**MEDICATIONS:** Please list (or show us your own printed record) **all** prescriptions 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).

| Medication | Dose (e.g. mg/pill) | How many times per day? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**ALLERGIES or intolerance to medications?** □ **NONE**

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

**IMMUNIZATIONS:** Enter year (if known) of any vaccinations you have had.

Tetanus (Td)_____ With Pertussis (Tdap)_____ Varicella (Chicken Pox) shot *or* illness_____ Pneumovax (pneumonia) _____

Influenza (flu shot)_____ Hepatitis A_____ Hepatitis B_____ MMR_____ Meningitis _____ Zostavax (shingles)_____ HPV _____

**HEALTH MAINTENANCE SCREENING TESTS:**

Lipid (cholesterol) Date_____ Result, if known _____

Sigmoidoscopy or Colonoscopy (circle one) Date (year)_____ Abnormal? □ No □ Yes
Polyp? □ No □ Yes

***Women only:***

Mammogram Most recent date/where _____ Abnormal? □ No □ Yes

Pap Smear Most recent date/where _____ Abnormal? □ No □ Yes

**please go to next page**

**PERSONAL MEDICAL HISTORY**: Do you have now or have you had (past) any of the following conditions?

| ***Condition*** | ***Now*** | ***Past*** | ***Comments*** |
|---|---|---|---|
| Alcohol / Drug abuse | | | |
| Allergy (Hay Fever) | | | |
| Anemia | | | |
| Anxiety | | | |
| Arthritis (Rheumatoid) | | | |
| Arthritis (Osteoarthritis) | | | |
| Asthma | | | |
| Bladder / Kidney Problems | | | |
| Blood Clot (leg) | | | |
| Blood Clot (lung) | | | |
| Blood Transfusion | | | |
| Breast Lump (benign) | | | |
| Cancer Breast | | | |
| Cancer Colon | | | |
| Cancer Other Type | | | |
| Cancer Prostate | | | |
| Chicken Pox | | | |
| Colon Polyp | | | |
| Coronary Artery Disease | | | |
| Depression | | | |
| Diabetes (adult onset) | | | |
| Diabetes (childhood onset) | | | |
| Diverticulosis | | | |
| Emphysema (COPD) | | | |
| Fractures (broken bones) | | | Where? |
| Gallbladder Disease | | | |
| Gastroesophageal Reflux (Heartburn/GERD) | | | |
| Gout | | | |
| Gynecological Conditions (Endometriosis) | | | |
| Gynecological Conditions (Other) | | | |
| Heart Attack | | | |
| Hepatitis | | | |
| High Blood Pressure | | | |
| High Cholesterol | | | |
| Irritable Bowel Syndrome | | | |
| Kidney Disease / Failure | | | |
| Kidney Stones | | | |
| Liver Disease | | | |
| Migraine Headaches | | | |
| Osteoporosis | | | |
| Pneumonia | | | |
| Prostate (enlargement) | | | |
| Prostate (nodules) | | | |
| Seizure / Epilepsy | | | |
| Skin Condition | | | |

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| *Condition* | *Now* | *Past* | *Comments* |
|---|---|---|---|
| Sleep Apnea | | | |
| Stomach Ulcer | | | |
| Stroke | | | |
| Thyroid (Nodule) | | | |
| Thyroid High (Overactive) / Hyperthyroidism | | | |
| Thyroid Low (Underactive) / Hypothyroidism | | | |
| Other (list) | | | |
| Other (list) | | | |

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

**SURGICAL & PROCEDURE HISTORY** – Please check off any procedure or surgeries. List any abnormal finding, details or complications under comments.

| *Surgical Procedure* | *Yes* | *Year* | *Comments* |
|---|---|---|---|
| Abdominal surgery | | | |
| Angiogram (heart) | | | |
| Angiogram (vascular) | | | |
| Appendectomy (appendix removal) | | | |
| Back surgery (lumbar) | | | |
| Biopsy (location in comments) | | | |
| Breast Biopsy | | | Circle: Right Left Both |
| Breast surgery | | | Circle: Right Left Both |
| Cataract surgery | | | |
| Colonoscopy | | | |
| Coronary Bypass | | | |
| Coronary Stent | | | |
| C-Section | | | |
| Echocardiogram (heart) | | | |
| EGD (Stomach Endoscopy) | | | |
| Gallbladder Removal | | | Circle: Laparoscopic (HX0271) |
| Heart Surgery (other than coronary bypass checked above) | | | |
| Hip Surgery | | | Circle: Right Left Both |
| Hysterectomy (partial, ovaries left) | | | Circle: Laparoscopic Vaginal Abdominal |
| Hysterectomy (total, including ovaries) | | | Circle: Laparoscopic Vaginal Abdominal |
| Knee Surgery | | | Circle: Right Left Both |
| LEEP (Cervix surgery) | | | |
| Neck (Spine) surgery | | | |
| Ovary Removal | | | Circle: Right Left Both |
| Pulmonary Function Test | | | |
| Sigmoidoscopy | | | |
| Sinus Surgery | | | |
| Stress Test (stress echo) | | | |
| Stress Test (thallium/perfusion) | | | |
| Stress Test (treadmill) | | | |
| Tonsillectomy | | | |
| Tubal ligation | | | |
| Vasectomy | | | |
| Other (list) | | | |

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

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**FAMILY HISTORY**

**Adopted? □ No □ Yes. If adopted and you do <u>not</u> know your family history skip the Family History section and continue to Health Issues on the next page.**

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)* | *List age(s) at diagnosis if known and if this was the cause of death* |
|---|---|---|---|---|---|---|---|---|---|---|
| **No significant history known** | | | | | | | | | | |
| Hypertension – high blood pressure | | | | | | | | | | |
| Hyperlipidemia – high cholesterol | | | | | | | | | | |
| Heart Attack, Angina (Coronary Artery Disease) | | | | | | | | | | |
| Diabetes Type II (adult onset) | | | | | | | | | | |
| Cancer, Breast | | | | | | | | | | |
| Cancer, Colon | | | | | | | | | | |
| Cancer, Prostate | | | | | | | | | | |
| Osteoporosis | | | | | | | | | | |
| Depression | | | | | | | | | | |
| Alcoholism / Drug abuse | | | | | | | | | | |
| Alzheimers | | | | | | | | | | |
| Asthma | | | | | | | | | | |
| Autoimmune Disease | | | | | | | | | | |
| Bleeding or Clotting Disorder | | | | | | | | | | |
| Cancer, Lung | | | | | | | | | | |
| Cancer, Ovarian | | | | | | | | | | |
| Cancer, Other type | | | | | | | | | | |
| Colon Polyp | | | | | | | | | | |
| Diabetes Type I (childhood onset) | | | | | | | | | | |
| Emphysema (COPD) | | | | | | | | | | |
| Genetic Disorder (explain) | | | | | | | | | | |
| Glaucoma | | | | | | | | | | |
| Heart Disease (CHF) | | | | | | | | | | |
| Heart Disease (Other) | | | | | | | | | | |
| Hepatitis B or C | | | | | | | | | | |
| Hip Fracture | | | | | | | | | | |
| Hypothyroidism / Thyroid Disease | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | |
| Kidney Stones | | | | | | | | | | |
| Macular Degeneration | | | | | | | | | | |
| Stroke | | | | | | | | | | |
| Sudden Cardiac Death | | | | | | | | | | |
| Other (list) | | | | | | | | | | |
| Other (list) | | | | | | | | | | |

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**HEALTH ISSUES:**

**Tobacco Use:**

Smoke or smoked cigarettes/ pipe/ cigars (circle)? □ Never □ Yes

Exposure to second hand smoke? □ No □ Yes

(If never used any tobacco can skip to Alcohol Use section below)

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

Former smoker: Quit date: _____

Approximately how many packs/day did you smoke? _____

How many years did you smoke? _____

Other tobacco? (circle) Snuff or Chew

Quit date _____ Currently use? □ Yes

Are you ready to quit? □ No □ Yes

**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) >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? _____

**Please continue to next column on right**

**Sexual Activity:**

Are you sexually active: □ Not currently □ Never □ Yes

Sexual partner(s) is/are/have been/may be in future: □ male □ female

Birth control method or STD prevention (check all that apply):

□ None needed □ Condom □ Pill □ IUD □ Patch □ Ring

□ Diaphragm □ Vasectomy □ Tubal ligation

□ Other method

(specify):_____

**Other (ADL):**

Military Service? □ No □ Yes

Blood Transfusion? □ No □ Yes

Exposure to toxic chemicals at work? □ No □ Yes

Exposure to toxic chemicals doing hobbies? □ No □ Yes

**Diet:**

Do you follow a special diet? □ No □ Yes

vegetarian, vegan, gluten free, other _____

**Exercise:** Do you exercise regularly? □ Yes □ No

If yes, what kind of exercise? _____

How long (minutes)?_____How often? _____

Do you use a helmet for recreational activities? (e.g. bike, skateboard, ski) □ Not applicable □ Yes □ No

Do you use seatbelts consistently? □ Yes □ No

In the past 2 weeks: Have you been feeling down, depressed or hopeless? □ No □ Yes

Do you have little interest or pleasure in doing things? □ No □ Yes

**SAFETY:**

Does your home have a working smoke detector? □ Yes □ No

Do you have guns in your home? □ No □ Yes

If yes, are they locked up & ammo stored separately? □ Yes □ No

Have you or any family members ever been hurt, insulted, threatened or screamed at? □ No □ Yes

□ Pets (what type)_____ □ Other (roommates, extended family, etc) _____

Please list your interests, hobbies, group involvement, volunteer work, and/or travel outside of country in the past 6 months:

_____

_____

**please go to next page**

**SOCIOECONOMIC:**

Occupation (or prior occupation): _____ Employer: _____

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

□ other _____

Marital status: □ single □ partner □ married □ divorced □ widowed

Spouse/partner's name: _____

Number of children:_____Ages (if minors):_____

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

**WOMEN'S HEALTH HISTORY:**

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

Age at beginning of periods (menstruation): _____

Age at end of periods (menopause/hysterectomy): _____ □ Not applicable

Do you have concerns about your periods or menopause you'd like to discuss? □ No □ Yes

If you are having periods, how often do they occur? Every_____days. How long do they last?_____days.

**Thank-you for taking the time to complete this form!**