QUESTIONNAIRE: NEW ADULT PATIENT

Patient Name: _____ Date of Birth: _____

Preferred Name/Nickname: _____ Today's Date: _____

Medical History:

Condition	Year diagnosed/Specialist Name
☐ Asthma	_____
☐ Bladder/Kidney disorder	_____
☐ Blood disorder	_____
☐ Breast/GYN disorder	_____
☐ Cancer (_____)	_____
☐ Chronic ENT disorder	_____
☐ Depression/Anxiety	_____
☐ Diabetes	_____
☐ Gastrointestinal disorder	_____
☐ Heart Disorder	_____
☐ High Blood Pressure	_____
☐ High Cholesterol	_____
☐ Lung/COPD/Emphysema	_____
☐ Musculoskeletal disorder	_____
☐ Neurologic/Stroke/Seizure	_____
☐ Prostate Problem	_____
☐ Skin disorder	_____
☐ Thyroid disorder	_____
☐ Other: _____	_____

Past Testing

		Date Performed
Bone Density	☐ Yes ☐ No	_____
Colonoscopy	☐ Yes ☐ No	_____
EKG	☐ Yes ☐ No	_____
Mammogram	☐ Yes ☐ No	_____
Pap (females)	☐ Yes ☐ No	_____
Prostate (males)	☐ Yes ☐ No	_____
Pulmonary function	☐ Yes ☐ No	_____
Stress Testing	☐ Yes ☐ No	_____
Lung Cancer Screening	☐ Yes ☐ No	_____
Hepatitis C Screening	☐ Yes ☐ No	_____
HIV Screening	☐ Yes ☐ No	_____

Surgeries

Type	Date	Type	Date
☐ Abdominal	_____	☐ Orthopedic	_____
☐ Appendix	_____	☐ Prostate	_____
☐ Breast	_____	☐ GYN	_____
☐ Gall Bladder	_____	☐ Urologic	_____
☐ Heart	_____	☐ Other	_____

Social History

#Children: ____ #Miscarriages:____ Abortions:____

Occupation: _____

Years of Education/Highest Degree: _____

With whom do you live?

Alone ☐ Children ☐ Parents ☐ Spouse/Partner

☐ Extended Family ☐ Other

Tobacco Use: ☐ Cigarettes ☐ Never

☐ Pipe Quit Date _____

☐ Cigar Packs/day _____

☐ Snuff # of years _____

☐ Chew # cartridges/day: ____

☐ Vaping

Caffeine: ☐ Yes ☐ No ☐ Cups/day _____

Alcohol: ☐ Yes ☐ No ☐ Drinks/wk _____

Is alcohol a concern for you/others?

Yes No

Drug Use:

Have you ever used non-legalized drugs?

Yes No

Have you ever used needles to inject drugs?

Yes No

Other Concerns:

Weight: ☐ Yes ☐ No

Regular exercise: ☐ Yes ☐ No

What kind? _____

How long (minutes) _____ # _____/week

Do you follow a special diet? ☐ Yes ☐ No

Your safety:

Is violence at home a concern? ☐ Yes ☐ No

Have you ever been abused? ☐ Yes ☐ No

Do you fall frequently? ☐ Yes ☐ No

Have you completed:

☐ Advanced Healthcare Directive ☐ POLST

☐ Durable Power of Attorney ☐ Living Will

☐ Do not resuscitate order

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Patient Label

Social History (cont'd)

Over the Age of 65:

Do you have any concerns about activities of daily living? _____

Do you feel you have memory issues? Yes ☐ No

Do you feel you are at risk for falling? Yes ☐ No

MEDICATIONS

Medication	Dose	Times Per Day	Medication	Dose	Times Per Day

PHARMACY: What local pharmacy do you use? _____

What mail order pharmacy do you use? _____

ALLERGIES OR REACTIONS: To medication, food, environment, or other agent.

No known allergies

Medication, Food, Other	Reaction or Side Effect	Date it Occurred

Family History: ☐ Adopted ☐ Family History Unknown

Check all that applies to each family member.	Mental Health Disorder	Alcohol	Breast Cancer	Colon Cancer	Prostate/ Uterine Cancer	Lung Cancer	Diabetes	High Blood Pressure	High Cholesterol	Cause of Death	Other
Mother											
Father											
Sisters											
Brothers											
Maternal Grandfather											
Maternal Grandmother											
Paternal Grandfather											
Paternal Grandmother											
Other:											

Patient Education:

Patient education is important to us. We would like to know your learning style preferences. Please mark your preference(s):

Verbal | Read | | Demonstration _ Other: _____

Do you have any limitations that would interfere with education that we need to provide to you (such as cultural, visual, hearing, religious, etc.)?

¯ No Yes If yes, please explain: _____

Privacy & Confidentiality

Please list anyone you would like to give permission for us to talk to about your healthcare services:

_____

I have carefully reviewed this questionnaire and have completed it to the best of my knowledge.

Patient/Representative Signature: _____ Date: _____ Time: _____

Relationship to Patient: _____

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