# Name Date

**Comprehensive Adult New Patient Health History Questionnaire**

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update form you can use. 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

## HEALTH MAINTENANCE SCREENING TESTS:

Zostavax (shingles) HPV

Lipid (cholesterol) Date Sigmoidoscopy or Colonoscopy (circle one) Date (year)

Result, if known Abnormal? □ No □ Yes

***Women only:*** Polyp? □ No □ Yes

Mammogram Most recent date/where

Pap Smear Most recent date/where

Bone Density Test Most recent date/where

Abnormal? □ No □ Yes

Abnormal? □ No □ Yes

Abnormal? □ No □ Yes

**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 Ovarian |  |  |  |
| Cancer Prostate |  |  |  |
| Cataracts |  |  |  |
| 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) |  |  |  |
| Glaucoma |  |  |  |
| Gout |  |  |  |
| Gynecological Conditions (Endometriosis) |  |  |  |
| Gynecological Conditions (Fibroids) |  |  |  |
| Gynecological Conditions (Other) |  |  |  |
| Heart Attack |  |  |  |
| Hepatitis – Type A |  |  |  |
| Hepatitis – Type B |  |  |  |
| Hepatitis – Type C |  |  |  |
| Hepatitis – Other |  |  |  |
| High Blood Pressure |  |  |  |
| High Cholesterol |  |  |  |
| Hip Fracture |  |  |  |
| Irritable Bowel Syndrome |  |  |  |
| Kidney Disease / Failure |  |  |  |
| Kidney Stones |  |  |  |
| Liver Disease |  |  |  |
| Migraine Headaches |  |  |  |
| Osteoporosis |  |  |  |
| Pneumonia |  |  |  |
| Prostate (enlargement) |  |  |  |
| Prostate (nodules) |  |  |  |
| Seizure / Epilepsy |  |  |  |
| Skin Condition (Eczema) |  |  |  |

## Personal History continued

|  |  |  |  |
| --- | --- | --- | --- |
| ***Condition*** | ***Now*** | ***Past*** | ***Comments*** |
| Skin Condition (Psoriasis) |  |  |  |
| Skin Condition (Abnormal Moles) |  |  |  |
| 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*** | ***Code*** | ***Yes*** | ***Year*** | ***Comments*** |
| Abdominal surgery | HX0004 |  |  |  |
| Angiogram (heart) | HX0541 |  |  |  |
| Angiogram (vascular) | HX0503 |  |  |  |
| Appendectomy (appendix removal) | HX0023 |  |  |  |
| Back surgery (lumbar) | HX0032 |  |  |  |
| Biopsy (location in comments) | HX0524 |  |  |  |
| Breast Biopsy | HX0043 |  |  | Circle: Right Left Both |
| Breast surgery | HX0056 |  |  | Circle: Right Left Both |
| Cataract surgery | HX0196 |  |  |  |
| Colonoscopy | HX0095 |  |  |  |
| Coronary Bypass | HX0526 |  |  |  |
| Coronary Stent | HX0243 |  |  |  |
| C-Section |  |  |  |  |
| Echocardiogram (heart) |  |  |  |  |
| EGD (Stomach Endoscopy) | HX0491 |  |  |  |
| Gallbladder Removal | HX0349 |  |  | Circle: Laparoscopic (HX0271) |
| Heart Surgery(other than coronary bypass checked above) |  |  |  |  |
| Hip Surgery | HX0224 |  |  | Circle: Right Left Both |
| Hysterectomy (partial, ovaries left) |  |  |  | Circle: Laparoscopic Vaginal Abdominal |
| Hysterectomy (total, including ovaries) | HX0600 |  |  | Circle: Laparoscopic Vaginal Abdominal |
| Knee Surgery | HX0261 |  |  | Circle: Right Left Both |
| LEEP (Cervix surgery) | HX0105 |  |  |  |
| Neck (Spine) surgery | HX0554 |  |  |  |
| Ovary Removal | HX0355 |  |  | Circle: Right Left Both |
| Pulmonary Function Test | INT0015 |  |  |  |
| Sigmoidoscopy | HX0426 |  |  |  |
| Sinus Surgery | HX0427 |  |  |  |
| Stress Test (stress echo) | HX0433 |  |  |  |
| Stress Test (thallium/perfusion) | HX0294 |  |  |  |
| Stress Test (treadmill) | HX0191 |  |  |  |
| Tonsillectomy | HX00535 |  |  |  |
| Tubal ligation | HX00536 |  |  |  |
| Vasectomy | HX0356 |  |  |  |
| Other (list) |  |  |  |  |

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

**FAMILY HISTORY**

**Adopted? □ No □ Yes. If adopted and you do not 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) |  |  |  |  |  |  |  |  |  |  |

## 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)

## Sexual Activity:

Are you sexually involved: □ 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

Current smoker: Packs/day:

# of years:

* + Other method

(specify):

Former smoker: Quit date:

|  |  |  |
| --- | --- | --- |
| **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:** |  |  |

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

Do you follow a special diet?

|  |  |  |
| --- | --- | --- |
| Are you ready to quit?**Alcohol Use:** | * No
 | * Yes
 |
| Do you drink alcohol? | * No
 | * Yes
 |

* + - No □ Yes

vegetarian, vegan, gluten free, other

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

# of drinks/week:

* Beer □ Wine □ Liquor

If yes, what kind of exercise?

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?

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

## SAFETY:

**Please continue to next column on right**

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

* Yes

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

## SOCIAL DOCUMENTATION:

Name you prefer we use when contacting you (nickname, first, or last with Mr, Mrs, Ms, etc): Country of birth:

Who lives at home with you: □ No one □ Spouse/partner □ Children

* + 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:

## 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): # of grandchildren: # of great grandchildren:

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

## MEDICAL FORMS:

Please check any of the following forms you have completed:

* Advance Directive for Health Care (ADHC)
* Durable Power of Attorney (DPA) for healthcare decisions
* Living Will
* POLST (Physician Orders for Life Sustaining Therapy)
* Know about these or have the forms but have not completed them
* Don’t know what these are

## 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!