



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 \_\_\_\_\_ 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  
 Bone Density Test \_\_\_\_\_ Most recent date/where \_\_\_\_\_ Abnormal?  No  Yes

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

<i>Condition</i>	<i>Now</i>	<i>Past</i>	<i>Comments</i>
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

<i>Condition</i>	<i>Now</i>	<i>Past</i>	<i>Comments</i>
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.

<i>Surgical Procedure</i>	<i>Code</i>	<i>Yes</i>	<i>Year</i>	<i>Comments</i>
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										
<i>Diseases &amp; Conditions</i>	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	<i>Other blood relatives (list relationship to you)</i>	<i>List age(s) at diagnosis if known and if this was the cause of death</i>
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)

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

**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

**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:

\_\_\_\_\_  
\_\_\_\_\_

**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  
 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

**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!**