Adult New Patient Questionnaire

Date completed: _____/_____/_____

PERSONAL INFORMATION

Name: _____ Date of birth: _____/_____/_____

What is your primary language? _____

Do you have special needs in any of the following areas?

❑ Reading ❑ Vision ❑ Hearing ❑ Mobility (e.g., wheelchair, walker, etc.) ❑ Communication (e.g., need for a translator)

HOME
❑ Single ❑ Long-term partner ❑ Married ❑ Civil Union ❑ Divorced ❑ Separated ❑ Widowed

List your children with ages: _____

_____

List current members of your household: _____

EMPLOYMENT

❑ Full-time ❑ Part-time ❑ At home/homemaker ❑ Looking ❑ Disabled ❑ Retired
❑ Student (school:_____)

Current occupation: _____ Former occupation (if retired): _____

Employer: _____

ALLERGIES List medication allergies and the type of reaction you had. ❑ **I have no drug allergies**

_____ _____

_____ _____

MEDICATIONS List with doses. Include contraceptives, vitamins, supplements, etc. Attach list if needed. ❑ **None**

_____ _____

_____ _____

_____ _____

_____ _____

Name: _____

YOUR MEDICAL CONDITIONS (check all that apply)

❑ Allergies ❑ Anemia ❑ Anxiety ❑ Arthritis ❑ Asthma ❑ Blood transfusion ❑ Cancer ❑ Clotting disorder ❑ Congestive heart failure ❑ Depression ❑ Diabetes mellitus ❑ Emphysema/COPD ❑ Gastroesophageal reflux disease (GERD) ❑ Glaucoma ❑ Heart murmur ❑ HIV/AIDS ❑ High cholesterol ❑ Hypertension/high blood pressure ❑ Kidney disease ❑ Myocardial infarction ❑ Nerve/muscle disease ❑ Osteoporosis ❑ Seizures ❑ Sickle cell anemia ❑ Substance abuse ❑ Thyroid disease ❑ Tuberculosis

Details/Other:

_____

_____

SURGICAL HISTORY (check all that apply)

❑ Appendectomy ❑ Brain surgery ❑ Breast surgery ❑ CABG ❑ Cholecystectomy ❑ Colon surgery ❑ Tonsillectomy ❑ Appendectomy ❑ Thyroid surgery ❑ Lung surgery ❑ C-section ❑ Eye surgery ❑ Fracture surgery ❑ Hernia repair ❑ Hysterectomy ❑ Joint surgery ❑ Bunionectomy ❑ Varicose vein surgery ❑ Prostate surgery ❑ Weight reduction surgery ❑ Small intestine surgery ❑ Spine surgery ❑ Tubal ligation ❑ Valve replacement ❑ Vasectomy ❑ Vascular surgery ❑ Cardiac stent ❑ Bladder surgery

Have you ever had a blood transfusion? ❑ No ❑ Yes (approximate dates: _____)

FAMILY HISTORY (check all that apply)	**Breast cancer**	**Ovarian cancer**	**Prostate cancer**	**Other cancer(s)**	**Diabetes**	**Heart disease**	**High cholesterol**	**Hypertension**	**Mental illness**	**Alcohol abuse**
Mother										
Father										
Sister										
Brother										
Daughter										
Son										
Other relative										

Other Family History: _____

_____

_____