New Patient Questionnaire

Date: ___________

Name: ___________________________

Do you have a regular Doctor? Y___ N___ (If so, who?) _______________________

Have you traveled outside the United States in the past 6 months? Y____ N____

(If so, where):__________________________________

Allergies

Please list Medication Allergies: ____

Latex Allergy Y___ N___

Contraception

What is your current Birth Control? Pills___ IUD___ Ring___ Depo___ Nexplanon___ Condoms__ Withdrawal___

Other please specify: _________________________

What have you used in the past? Pills__ IUD__ Ring__ Depo__ Nexplanon__ Condoms__Withdrawal__
Other please specify: _________________________

Current Medication

Name	Dosage

Vaccinations:	**Date of last one:**	**Check if you’ve had**

Td, Tdap		
Influenza		
Pneumonia		
Hepatitis A		
Hepatitis B		
Shingles		
HPV		
MMR		
Meningitis		

Health Risk Assessment

Test:	Date of last one:	Check if you've had
Stool cards for colon Cancer testing:		
Colonscopy		
Sigmodoscopy		
Bone Density		
Mammogram		
Pap Smear		
PSA (men only)		

Smoking History: Check which one applies

Never Smoked____ Former Smoker____ Current Smoker____ Other tabacco use_____

Do your drink wine, beer, or other alcoholic beverages?____ If yes, how much daily?_____ Weekly?____

Do you use marijuana, opioids or other recreational drugs? Y___ N____

Have you ever used needles to inject drugs? Y___ N___

Do you wear your seat belts? Y ___ N___ Sometimes___

Social Lifestyle

What is your current Occupation: Homemaker____ Employed_____ Unemployed______

Highest Grade completed in School: __________

Marital Satus: Single___ Partner___ Married___ Divorced___ Widow___ Other______

<u>Womens Health</u>

Frist day of last menstrual period _________ Age at first Menstrual Period______ Never Been Pregnant______
List all pregnancies if applicable:

Number of Pregnancies	Less than<37 weeks	More than> 37 semanas	Problems with Pregnancies	Number of live Births

Have you ever had depression or postpartum depression? Y_____ N_____

Do you want to get pregnant? Y____ N____

Patient Health

	Yes	No
Adnormal Pap Smear		
Anemia		
Anxiety		
Asthma		
Bladder/Kidney Problems		
Breast		
Blood Transfusion		
Cancer		
Depression		
Diabetes		
Heart Problems		
Hepatitis		
High Blood Pressure		
High Cholesterol		
HIV Infection		
Kidney Problems		
Migraine Headaches		
Seizure/ Epilepsy		
Stroke		
Thyroid Problems		
Other please Specify:		

Family History

	Yes	No
Adopted has no knowledge of Family History		
Anemia		
Anxiety		
Asthma		
Alcoholism		
Alzheimer's		
Blood Transfusion		
Cancer		
Depression		
Diabetes		
Heart Problems		
High Blood Pressure		
Thyroid Problems		
Other please Specify:		

Date:	**Please list all Surgeries**