FAMILY PRACTICE DOCTORS

"IT'S ALL ABOUT THE FAMILY"

New Patient Questionnaire **PATIENT NAME** _____ **D.O.B** _____

1. **Medication List: (<u>If more space is needed please use back of sheet</u>)**

Name of Medication	**Dose**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of your pharmacy _____ Phone: _____

2**. Do you have any known allergies?** _____

3. **Past Medical History**:

_____ _____

_____ _____

_____ _____

4. **Past Surgical History:**

_____ _____

_____ _____

5. **Family Medical History: (please circle all that apply)**

A. Mother (Living / Deceased) - Diabetes / High Blood Pressure / Heart Problems / Cancer
Father (Living / Deceased) - Diabetes / High Blood Pressure / Heart Problems / Cancer
Siblings (Living / Deceased) - Diabetes / High Blood Pressure / Heart Problems / Cancer
Grandmother (Living / Deceased) - Diabetes / High Blood Pressure / Heart Problems / Cancer
Grandfather (Living / Deceased) - Diabetes / High Blood Pressure / Heart Problems / Cancer

B. How many children do you have? Male _____ Female _____

6. **Social History: (please circle all that apply)**

A. Are you a smoker? Yes / No How many Cigarettes per day? _____ How many years? _____
B. How soon after you wake up do you have your first cigarettes? 5Min / 30Min / 1Hr / Longer then 1hr
C. Do use alcohol? Yes / No How many times a week? _____ How many drinks? _____
D. Do you use illegal drugs? Yes / No If yes, what type? _____
E. Are you sexually active? Yes / No Do you practice safe sex? Yes / No

7. **General Health: (please circle all that apply)**

Date of last flu vaccine? ____/____/____ Would you like to receive flu vaccine? Yes / No
Do you generally feel fatigued or tired? Yes / No Would you like to receive a B12 shot? Yes / No
If over age 65yrs or have chronic health problems, have you received the pneumococcal vaccine? Yes / No

8. **Female (only): (please circle all that apply)**

Date of last menstrual ____/____/____ Do you have **<u>irregular</u>** menstrual cycles? Yes / No
Date of last pap smear? ____/____/____
Date of last mammogram? ____/____/____