UPTOWN FAMILY MEDICINE

New Patient Health Questionnaire

Please note this questionnaire is designed to get to know you, assess your current and previous health concerns, in an effort to provide you the best care possible. It is strictly confidential and the information will help build your patient profile.

Demographics

Patient Name:____

First *Middle* *Last* *Preferred name (If applicable)*

Gender: ________________________________ Date of Birth: _____ /____ /________
DD / MM / YYYY

Medicare Card #: _________________________ Expiration Date: ____ /________
MM / YYYY

Occupation: _________________________ Employer: _________________________________

Home Phone ( ) _________________ Alternate Phone ( ) _________________

Mobile Phone ( ) _________________ 2nd cell ❒ Work ❒ Other ❒_______________

Alternate Contacts

Next of Kin:__________________________ Relationship to Patient:_______________________

Contact Number: _____________________________

Do you have a Power of Attorney (POA)?

POA's Name_________________________ Relationship to Patient:_______________________

Contact Number: ( ) ____________________

Is your POA for (*check all that* apply): Personal Care ❒ Financial ❒

Insurance

Do you have an insurance provider outside of Medicare? (*i.e. for prescription medications*)

Yes ❒ No ❒

If yes, who is the insurance provider?____

What Pharmacy do you usually use for prescription refills? ____

Where are they located? ____

Social History

Marital Status:______________________________ Partners Name:_______________________________

Do you have children? Yes ❒ No ❒

If yes, what are their names and ages?____

Tobacco use: Never ❒ *If so, are you…*

Former smoker? ❒ quit when:_______ Interested in quitting? Yes ❒ No ❒

Current smoker? ❒ cigs/day: ________ Have you previously tried to quit smoking? Yes ❒ No ❒

If so, how did you do it?_________________

Alcohol use: No ❒ Never ❒

Yes ❒ How many drinks per week? ______________

Have you had a problem with alcohol use? Yes ❒ No ❒

Recreational drugs: Never ❒ If yes please specify:____

(including marijuana) In the Past ❒ ____

Currently ❒ ____

Caffeine: Yes ❒ No ❒ # cups/day:______________

Exercise: Daily ❒ Specify:____

Weekly ❒ ____

Never ❒ ____

Family History

Please list any illnesses, especially cancers that seem to run in the family:

____

____

____

Specifically, is there any history of:

Heart Attack ❒ Who:___________________________________ Age(s):_____________

Cancer ❒ Who:___________________________________ Age(s):_____________

Allergies / Sensitivities

Do you have medication allergies: Yes ❒No ❒

Do you have environmental allergies: Yes ❒No ❒

Personal Health History

Please check any and all that apply to you now or in the past….

Angina	❒	Arthritis	❒	Anorexia	❒
Heart attack	❒	Fibromyalgia	❒	Anxiety	❒
High blood pressure	❒	Gout	❒	Bipolar disorder	❒
High cholesterol	❒	Osteoporosis	❒	Depression	❒
Pacemaker	❒			Panic attacks	❒
Stroke / mini-stroke	❒	Thyroid disease	❒	Mental health	❒
Celiac disease	❒	Asthma	❒		
Crohn's disease	❒	COPD	❒	Alzheimer's	❒
Ulcerative colitis	❒	Emphysema	❒	Dementia	❒
Diverticulosis	❒	Sarcoidosis	❒	Seizure disorders	❒
IBS	❒			Other neurological	
Acid Reflux (GERD)	❒	Anemia	❒	disorder	❒
		Bleeding disorders	❒	Migraines	❒
Gallbladder issues	❒	Blood clots	❒	Sexually transmitted	
Hepatitis	❒	Liver disease	❒	infections	❒
Pancreatitis	❒	Cancer	❒	Eczema	❒
Kidney stones	❒	Psoriasis	❒	Cataracts	❒
Kidney disease	❒	Rashes	❒	Hearing loss	❒

Woman's Health

Difficulty getting pregnant ❒ Endometriosis ❒

Polycystic ovarian syndrome ❒ Heavy Periods ❒

Pregnancy History: **# of pregnancies** ___ **# vaginal deliveries** ___**# Caesarian sections** ___

Were there any complications in your pregnancy or deliveries:

____

____

____

Contraception / Birth control Yes ❒ No ❒ What name?:________________________________

Are you planning on becoming pregnant now or in the near future? Yes ❒ No ❒

Have you had a mammogram? Yes ❒ No ❒ Last was when?: ______________

When was your last Pap test? Never ❒ Last was when?: ______________

Have you had abnormal Paps? Yes ❒ No ❒ Previous Colposcopy? Yes ❒ No ❒ If yes when:____________

Men's Health

Erectile dysfunction ❒ Difficulty with urination ❒ Prostate issues ❒

Have you previously had prostate cancer testing (e.g. PSA)? Yes ❒ No ❒

Would you like to discuss future screening? Yes ❒ No ❒

Screening

Have you had…

Stool tests for colon cancer? Yes ❒No ❒ Year: ______________________

A colonoscopy? Yes ❒No ❒ Year: ______________________

Osteoporosis testing Yes ❒No ❒ Year: ______________________

Hospitalizations

Please list any previous hospitalizations

Reason	Year	Length of stay

Surgeries

Please list any previous surgeries

Type of surgery	Year	Length of stay

Immunizations

When was you last **tetanus shot**? >10 years ago ❒ >5 years ago ❒ <5 years ago ❒

Have you previously gotten the '**flu shot**'? Yes ❒ When:_____

Have you gotten the ***Twinrix®*** (Hepatitis A & B) vaccine? Yes ❒ When:_____

Have you gotten the ***Pneumovax®23*** (pneumonia) vaccine? Yes ❒ When:_____

Have you gotten the ***Prevnar®13*** (pneumonia) vaccine? Yes ❒ When:_____

Have you gotten the ***Zostavax®*** (Shingles) vaccine? Yes ❒ When:_____

Have you gotten the **Gardasil®*13*** (HPV) vaccine? Yes ❒ When:_____

Have you gotten the whooping cough (pertussis) vaccine? Yes ❒ When:_____

Have you received other vaccines and when?____