Uptown Family Medicine - Dr. Sheldon Wood

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.

Patient Name: ____

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

Medicare Number: ____________________ Exp Date: ____________________

Gender Identity: ____________________ Preferred Pronouns: ____________________

Email: ____________________

Home Phone: ( ) ________________ Mobile Phone: ( ) ________________

Preferred : Home ❐ Cell ❐

Employer: ____________________ Occupation: ____________________

Pharmacy ____________________ Pharmacy Location: ____________________

Alternate Contacts:

Next of Kin: ________________ Relationship to Patient: ______________ Contact Number: ( )____________

Do you have a Power of Attorney (POA)?

POA 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? ____

Tobacco use:

Never ❐

Former smoker? ❐ quit when:_______

Current smoker? ❐ cigs/day: ________

If so, are you…

Interested in quitting? Yes ❐ No ❐

Tried to quit smoking? Yes ❐ No ❐

Alcohol use:

No ❐ Never ❐

Yes ❐ How many drinks per week? _____________

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

Recreational drugs *(including marijuana)* Never ❐ Currently ❐ In the Past ❐

If yes please specify:____

Family History:
Please list any illnesses, especially cancers and heart disease, that seem to run in the family and the age at diagnosis:

___

___

___

Drug Allergies or Sensitivities? Yes ❒ No ❒ Environmental allergies: Yes ❒ No ❒

Drug	*Reaction*
___	___
___	___

Personal Health History: *Medical conditions, previous surgeries, previous hospitalizations:*

___

___

___

___

___

___

Do you see any Specialist doctors? Please list their name and specialty:

Physician name	*Specialty*	*Year and reason for seeing*
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___

Medications and supplements: (attach a list for additional items)

___ **strength** ___ **dosage** ___ **reason** ___

___ **strength** ___ **dosage** ___ **reason** ___

___ **strength** ___ **dosage** ___ **reason** ___

___ **strength** ___ **dosage** ___ **reason** ___

___ **strength** ___ **dosage** ___ **reason** ___

Women's Health:

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

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 ❒

Men's Health:

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

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

Other Screening: *When was your last…*

Colonoscopy? Yes ❒ No ❒ Year: _________

Routine blood work? Year: _________

Immunizations:

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

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

Have you had the whooping cough (pertussis) vaccine? Yes ❒ When: __________

Have you gotten a COVID vaccine? Yes ❒ How many?: __________

Have you received other vaccines and when? ____

____

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