



**NEW PATIENT MEDICAL INTAKE QUESTIONNAIRE**

NAME: \_\_\_\_\_ GENDER: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

**ALL MEDICATIONS: (Including over-the-counter medications and vitamins). Specific doses and when taken. If you don't know, please call your pharmacist to confirm.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**PERSONAL MEDICAL HISTORY:** (Please circle all that apply)

ADHD/ADD	Diabetes: Type 1 or 2	Kidney Disease/Stones
Alcoholism/Substance Abuse	Diverticulosis/Diverticulitis	Liver Disease/Cirrhosis
Anemia	Eczema/Psoriasis/Rashes/Acne	Mental Illness: Anxiety/Depression/Bipolar
Arrhythmias/Irregular Heartbeat	Fibromyalgia	Neuropathy
Arthritis	Headaches/Migraines	Osteopenia/Osteoporosis
Asthma/COPD/Emphysema	Hearing Impairment	Pulmonary Embolism/Blood Clots
Autoimmune Disorders: AS/Lupus/Thyroid/RA	Heart Disease: Heart Attack/Chest Pain/Angina	Seasonal Allergies
Back Pain/Neck Pain	Heavy Menstrual Bleeding/Cramping	Seizure Disorder
Bladder Problems/Incontinence	Hepatitis: A B C / HIV	Sleep Apnea/Sleep Disorder
Cancer: _____	Hernia: _____	Stroke
Chron's/Celiac Disease/Ulcerative Colitis	High Blood Pressure/High Cholesterol	Vision Problems/Glaucoma
Dementia/Alzheimer's	IBS/GERD/Stomach Ulcer	Weight Gain/Weight Loss

Last Menstrual Period Date: \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

Last Colonoscopy Date: \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

Last Mammogram Date: \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

Last Dexa (Bone Density Scan): \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

Last Pap Smear: \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

Last Diabetic Retinal Screen \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

Other medical problems not listed above:

\_\_\_\_\_

\_\_\_\_\_

Surgical History:

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL/CULTURAL HISTORY**

Education Level:  Elementary  High School  Vocational  College  Graduate / Professional

Are there any vision/hearing problems that affect your communication?  Yes  No

Are there any limitations to understanding or following instructions (either written or verbal)?  Yes  No

Are there any problems or concerns at home, work or school you would like to discuss?  Yes  No

Are there any cultural or religious concerns you have related to our delivery of care?  Yes  No

Are there any financial issues that directly impact your ability to manage your health?  Yes  No

How often do you get social and emotional support?  Always  Usually  Sometimes  Rarely  Never

**Current Living Situation (Check all that apply):**

Single Family  Multi-generational  Homeless  Shelter  Skilled Nursing Facility  Other: \_\_\_\_\_

Smoking/Tobacco Use:  Current  Past  Never Type: \_\_\_\_\_ Amount/day: \_\_\_\_\_ Number of Years \_\_\_\_\_

Alcohol:  Current  Past  Never Drinks/Week: \_\_\_\_\_

Recreational Drug Use:  Current  Past  Never Type: \_\_\_\_\_

Are you sexually active?  Yes  No

Comments (Please feel free to comment on any answers marked "yes" above):

\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY:**

**FATHER:** Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_

Alcoholism	Bipolar	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia/Alzheimer's	Heart Disease	Migraines	

Other: \_\_\_\_\_

**MOTHER:** Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_

Alcoholism	Bipolar	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia/Alzheimer's	Heart Disease	Migraines	

Other: \_\_\_\_\_

**SIBLINGS:**

\_\_\_\_\_  
\_\_\_\_\_

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_