

**Alder Brook Family Health
NEW PATIENT QUESTIONNAIRE,**

Name: _____ Date of Birth: _____ Today's date: _____

1. Your typical Day and Health Habits

Circle what best describes your situation: Single, Married, Divorced, Widowed, Engaged, Partnership, Civil Union, Committed relationship

Relationships and ages of those living with you _____

Time you get up: _____ Time you go to bed: _____ Work hours: _____

Occupation: _____

Occupation of partner/spouse _____

Please describe your typical meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How many 8 oz servings of calcium rich foods (milk, cheese, yogurt) do you consume per day? _____

What do you do for exercise? _____

How many days per week? _____ How many hours per week? _____

What are your hobbies? _____

What else do you do for fun? _____

What religious social or community activities are you involved in? _____

1. Do you have a living will/ medical power of attorney? ----- Y N
2. Do you always wear your seatbelt? ----- Y N
3. Do you always wear a helmet when bicycling or motorcycling? ----- Y N
4. How many cups of caffeinated coffee, tea or soda do you drink per day? _____
5. Do you smoke? ----- Y N
How many cigarettes per day? _____
Did you smoke in the past? ----- Y N
When did you quit? _____
6. Do you chew tobacco? ----- Y N
7. Do you drink alcohol? ----- Y N
If no skip to question 12
8. What is your average number of drinks per day? _____
(1 drink = 1.5 oz liquor, 12 oz. beer, or 5 oz. wine)
9. Have you been concerned enough about your drinking to feel you should cut down? -----Y N
10. Have you been annoyed by people's comments about your drinking? ----- Y N
11. Have you ever felt guilty about your drinking? ----- Y N

- 12. Have you had a drink first thing in the morning to steady your nerves or get rid of a hangover? ----- Y N
- 13. Have you had a drink in the last 24 hours? ----- Y N
- 14. Have you ever had an alcohol problem? -----Y N
- 15. Do you use opiates, heroin, hallucinogens (such as LSD), cocaine or amphetamines (such as speed or crystal meth)? ----- Y N
Have you ever used these drugs in the past? -----Y N
Have you ever injected drugs? -----Y N
- 16. Do you use marijuana? -----Y N

MEDICAL HISTORY

Please list any known medical conditions (such as diabetes, high blood pressure, depression, etc...)

Please list any past surgeries:

Surgery	Doctor/hospital	Date

Please list any other hospitalizations:

Reason for hospitalization	Doctor/hospital	Date

Immunization Questions

- 1. Date of last Tetanus Shot _____
- 2. Have you had 2 measles shots? ----- Y N
- 3. Have you had a pneumonia vaccine? ----- Y N
- 4. Have you had or been vaccinated against chickenpox? ----- Y N
- 5. Are you exposed to blood or blood products?----- Y N
- 6. Have you had your spleen removed?----- Y N

MEDICATIONS: including prescription, over-the-counter, herbal. Add additional sheet if necessary:

<i>Medication</i>	<i>Dose</i>	<i>Reason prescribed</i>	<i>Doctor prescribing</i>

Drug allergies: (include latex and adhesive tape allergies, if present)

<i>Medication</i>	<i>Type of reaction</i>

Family History

Do you have a first-degree relative (parent, brother, sister, child) with:

	Y	N	relationship	age
a. heart attack, angina or heart surgery before age 60?				
b. breast cancer?-----				
c. colon cancer, rectal cancer or polyps?-----				
d. prostate cancer?-----				
e. ovarian cancer?-----				
f. diabetes or "sugar"?-----				
g. melanoma?-----				
h. glaucoma?-----				
i. osteoporosis?-----				
j. high cholesterol?-----				
k. aortic aneurysm?-----				

Are there any other diseases that run in your family? Specify please _____

REVIEW OF SYSTEMS

Endocrine

Have you had:

1. a recent weight loss of ten pounds or more without changing your diet or exercise? ----- Y N
2. severe fatigue causing loss of work?-----Y N
3. a thyroid problem or operation-----Y N
4. diabetes-----Y N

Urinary

Have you had?

1. frequent urinary tract infections?-----Y N
2. a kidney stone?-----Y N
3. blood in your urine?-----Y N
4. pain with urination?-----Y N
5. urgent need to urinate?-----Y N

Eyes, ears, nose, throat

Have you had:

- 1. failing vision not correctable by glasses?-----Y N
- 2. trouble with your hearing?-----Y N
- 3. persistent pain or difficulty in swallowing?---Y N
- 4. persistent sore throats?-----Y N
- 5. Are you seeing an eye doctor for problems? ---Y N
- 6. frequent nosebleeds? -----Y N

Skin

Have you had?

- 1. a changing skin mole?-----Y N
- 2. skin cancer?-----Y N
- 3. an unusual skin rash?-----Y N

Gastroenterology

Have you ever had?

- 1. vomiting of blood?-----Y N
- 2. frequent heartburn----- Y N
- 3. bloody bowel movements?-----Y N
- 4. significant change in bowel movements?-----Y N
- 5. an ulcer?-----Y N
- 6. diverticulitis or diverticulosis? -----Y N
- 7. a polyp or tumor in the bowel?-----Y N
- 8. gallstones?-----Y N
- 10. if over 50, have you had a colonoscopy?-----Y N

Musculoskeletal

- 1. Have you had back pain which caused you to miss work? -----Y N
- 2. Have you had pain and swelling in your joints making it difficult to function ?-----Y N
- 3. Have you ever suffered from gout?-----Y N

For Men Only

- 1. Have you had any urinary dribbling, frequent urination, difficulty starting or stopping urination?---Y N
- 2. Do you want to discuss any sexual problems?..---Y N
- 3. Do you have sex with ? **Circle: Men Women Both**
- 4. Have you had a sexually transmitted disease? Gonorrhea, Chlamydia, Genital warts, Herpes, HIV, syphilis Y N

For Women Only

- 1. Date of last menstrual period: _____
- 2. Do you think you may be pregnant? ----- Y N
- 3. What are you using for birth control? **Circle: birth control pills, IUD, Condoms, Nuvaring, Patch, Depo Shot, Tubes tied, partner had a vasectomy**
- 4. Have you been on hormone replacement?----- Y N
- 5. Have you had vaginal bleeding after menopause? -----Y N
- 6. Have you had bleeding between periods?-----Y N
- 7. Have you had an abnormal PAP smear?-----Y N
- 8. Do you want to discuss sexual problems?-----Y N
- 9. Have you had a sexually transmitted disease? (Gonorrhea, Syphilis, Herpes, Chlamydia, Genital warts, HIV) --- Y N
- 10. Do you have sex with ? **Circle: Men, Women, Both, Neither**
- 11. Have you had a new sexual partner since your last PAP smear?-----Y N

Cardiovascular/Respiratory

Have you had?

- 1. chest pain, heaviness or pressure?-----Y N
- 2. skipped or irregular heartbeats?-----Y N
- 3. breathlessness or cough that awakens you at night? ----- Y N
- 4. high blood pressure?-----Y N
- 5. ankle swelling?-----Y N
- 6. shortness of breath with exertion?----- Y N
- 7. calf pain with walking?----- Y N
- 8. cough lasting longer than a usual cold? Y N
- 9. coughing up blood?----- Y N
- 10. a positive TB test?-----Y N
- 11. high cholesterol or triglycerides ---Y N

Hematologic

Have you had?

- 1. a bleeding disorder or hemophilia?----- Y N
- 2. jaundice or liver disease?-----Y N
- 3. malaria?-----Y N
- 4. your spleen removed?-----Y N
- 5. anemia or low iron count-----Y N

Neurological

- 1. Are you regularly bothered by headaches that leave you unable to function or that are worsening?-----Y N
- 2. Have you ever had a stroke? -----Y N
- 3. Have you had seizures?-----Y N
- 4. Do you have Multiple sclerosis-----Y N

