QUESTIONNAIRE: NEW ADULT PATIENT

Patient Name:	Date of Birth:
Pharmacy:	Today's Date:

CURRENT MEDICATION Include dosage/frequency

Medication	Dosage	Frequency

MEDICAL HISTORY Please check current or past medical problems that you have had

- ☐ Vision Problems/Cataracts
- ☐ Hearing Problems
- ☐ Dental Problems
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Irregular Heart Beat
- ☐ Poor Circulation
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Gout
- ☐ Blood Transfusion
- ☐ Blood Clots
- ☐ Bleeding Problems
- ☐ Hay Fever/Allergy
- ☐ Skin Rashes
- ☐ Cancer
- ☐ Type: _____
- ☐ Ulcer/Reflux/Gastritis
- ☐ Hepatitis/Liver Disease
- ☐ Colitis
- ☐ Hemorrhoids
- ☐ Urine Infections
- ☐ Kidney Disease
- ☐ Urine Leakage
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Menopause Symptoms
- ☐ Sexual Problems
- ☐ Birth Control
- ☐ Venereal Disease
- ☐ HIV Disease
- ☐ Back/Spine Pain
- ☐ Arthritis
- ☐ Injured Joints
- ☐ Seizures
- ☐ Stroke
- ☐ Head Injury
- ☐ Headaches
- ☐ Tremors
- ☐ Anxiety
- ☐ Depression
- ☐ Substance abuse
- ☐ Sleep Problems
- ☐ Other: _____

Allergy	Reaction	Allergy	Reaction

SURGICAL HISTORY (continue on back of form, if more space is needed)

Date:	Type of Surgery:
Date:	Type of Surgery:
Date:	Type of Surgery:

HOSPITALIZATIONS

Date:	Reason for Hospitalization:
Date:	Reason for Hospitalization:
Date:	Reason for Hospitalization:

QUESTIONNAIRE: NEW ADULT PATIENT (cont.)

Patient Name: Date of Birth: Today's Date:

FAMILY HISTORY

Family Member	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Healthy	Unknown	Deceased
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:									
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:									
Son(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:									
Daughter(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:									
Brother(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:									
Sister(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:									

How many? Brothers: _____ Sisters: _____ Sons: _____ Daughters: _____

Other pertinent medical history:

SOCIAL HISTORY

☐ Yes	☐ No	Smoke?	☐ Current ☐ Former ☐ Never
		How many cigarettes do you smoke?	☐ Everyday ☐ Some days ☐ 5 or less per day ☐ 6-10 per day
			☐ 11-20 per day ☐ 21-30 per day ☐ 31 or more per day
			How soon after you wake do you smoke your first cigarette?
			☐ Within 5 min. ☐ 6-30 min. ☐ 31-60 min. ☐ after 60 min.
			Are you interested in quitting?
			☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit
☐ Yes	☐ No	Chew tobacco?	☐ Current ☐ Former ☐ Never
☐ Yes	☐ No	Drink alcohol?	Frequency:_____ Amount:_____ Type:_____ Year quit:_____
☐ Yes	☐ No	Have you ever used drugs other than for medical reasons?	
☐ Yes	☐ No	Exercise?	Frequency:
☐ Yes	☐ No	Caffeine?	Amount: Frequency:

Patient Name:			Date of Birth:	Today's Date:

SOCIAL HISTORY cont.

☐ Yes	☐ No	Currently sexually active?	☐ Males ☐ Females ☐ Both
☐ Yes	☐ No	Travel outside US?	Location:
☐ Yes	☐ No	Have you had any type of occupational exposure?	What kind: _____ _____
☐ Yes	☐ No	Smoke detector in house?	
☐ Yes	☐ No	Do you have pet(s)?	☐ Cats ☐ Dogs ☐ Other: _____
☐ Yes	☐ No	Do you feel safe at home?	

Patient education is important to us. We would like to know your learning style preferences: Please mark your preference(s):

☐ Verbal ☐ Read ☐ Demonstration ☐ Other _____

Do you have any limitations that would interfere with education that we need to provide to you (such as cultural, visual, hearing, religious, etc)?

☐ No ☐ Yes ☐ If yes, please explain _____

For whom do you give us permission to talk to regarding your healthcare services? _____

I have carefully reviewed this questionnaire and completed it to the best of my knowledge.

_____ _____

Signature of patient, parent or legal guardian (circle one) Date / Time