QUESTIONNAIRE: NEW ADULT PATIENT

Patient Name:	Date of Birth:
Provider:	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: _____

DRUG ALLERGIES/REACTIONS

Drug	Reaction	Drug	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:

central peninsula hospital
250 Hospital Place, Soldotna, AK 99669
(907) 714-4404 * www.cpgh.org

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?	
Marital Status?		☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Occupation?			
Religion?			
☐ 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?	

Name of Vaccine	Date Given	Name of Vaccine	Date Given
Hepatitis A		Pneumococcal	
Hepatitis B		PPD or Tb Skin Test	
HPV, Gardasil		Tetanus, Diphtheria, Pertussis Td or Tdap	
Influenza			
Measles, Mumps, Rubella (MMR)		Varicella (Chicken Pox)	
Meningococcal		Shingles	

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