Davis Sq Family Practice New Patient Health Questionnaire

Name:_____ Today's Date:_____

Preferred name, if different:_____ Date of Birth:_____

Please Note: **This is a confidential record of your medical history and will be kept in this office. Information contained here won't be released to any person except when you have authorized us to do**

Reason for today's visit and/or goals for your health care: *(List in order of importance)*

_____

_____

I identify my gender as: ☐Female ☐Male ☐Transgender/Female to Male ☐Transgender/Male to Female
☐ Prefer to Self-Describe:_____ ☐Choose Not to Disclose

Sexual Orientation: ☐Straight ☐Lesbian/Gay ☐Bisexual ☐Prefer to Self-Describe_____
☐Unsure ☐Choose Not to Disclose Preferred Pronoun(s):_____

Marital Status: ☐Single ☐Married ☐Partner ☐Divorced ☐Widowed ☐Other_____

Relationship Status: ☐Not Involved ☐Involved(☐men ☐women ☐both) ☐monogamous ☐non-monogamous

Are you happy in your current situation? ☐Yes ☐No

Place of birth:_____ Primary Language:_____

Highest Grade Completed: _____ Occupation:(if retired, previous occupation)_____

Work Status: ☐Full Time ☐Part Time ☐Self Employed ☐Per Diem ☐Not Employed ☐Disabled
☐On Active Military Duty ☐Student Full Time ☐Student Part Time ☐Volunteer

Live With: ☐Alone ☐Roommates ☐Partner ☐Spouse ☐Child(ren) ☐Parent(s) ☐Other_____

Exercise Habits:_____

How would you describe your diet?_____

Smoking Status*:* ☐Never ☐Former (Quit Date)_____ ☐Current (How Much)_____

Do you drink alcohol? ☐No ☐Yes

If yes, how often: ☐4 or more times a week ☐2-3 times/week ☐2-4 times a month, monthly or less

How many on a typical day you are drinking? ☐10 or more ☐7-9 ☐5 or 6 ☐3 or 4 ☐1 or 2

Do you feel safe? (home/work/in relationships)? ☐Yes ☐No _____

Have you ever been abused? ☐No ☐Yes (☐physically ☐sexually ☐emotionally)

Do you always use seat belts? ☐Yes ☐No Wear sunscreen? ☐Yes ☐No Bike/ski helmets? ☐Yes ☐No

Condoms always(if applicable)? ☐Yes ☐No Any guns in the home? ☐Yes ☐No

Medications *(List all medications you are taking regularly. Include over the counter, herbal, or natural remedies)*

Name	*Dose*	*How Often*	*Reason for Taking*	*Name*	*Dose*	*How Often*	*Reason for Taking*

Allergies: Are you allergic to any medications, foods, or other agents? ☐No ☐Yes **(If yes, list below)**

Medication/Substance	*Reaction/Side Effect*	*Medication/Substance*	*Reaction/Side Effect*

Surgeries: *(Please list surgery and approximate year)*

Year	Surgery	Hospital

Hospitalizations: (*Other than surgeries)*

Year	Reason	Hospital

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Family Medical	Year of Birth	Current state of Health	Age at Death	If deceased, cause	Comments
Father					
Mother					
Other Parent					
Brother or Sister					
Brother or Sister					
Brother or Sister					
Brother or Sister					
Spouse					
Partner(s)					
Child(ren)					

Have you or any of your blood relatives had:

	You	Mother	Father	Other *(Indicate relation)*
Alcohol or Drug Addiction	❑	❑	❑	❑ _____
Anxiety	❑	❑	❑	❑ _____
Asthma	❑	❑	❑	❑ _____
High Blood Pressure	❑	❑	❑	❑ _____
Cancer	❑	❑	❑	❑ _____
Cholesterol	❑	❑	❑	❑ _____
Depression	❑	❑	❑	❑ _____
Diabetes	❑	❑	❑	❑ _____
Headaches	❑	❑	❑	❑ _____
Heart Problems	❑	❑	❑	❑ _____
Joint Issues	❑	❑	❑	❑ _____
Stroke	❑	❑	❑	❑ _____
Head injury	❑	❑	❑	❑ _____
Other	❑	❑	❑	❑ _____

Systems Review: Please indicate those items that have been a recurrent or recent significant change.

Yes	No		Yes	No	
		Constitutional Symptoms			**Psychiatric**
____	____	Good health lately	____	____	Memory loss or confusion
____	____	Recent significant weight changes	____	____	Nervousness
____	____	Unusual fatigue or weakness	____	____	Insomnia
			____	____	Obsessive or compulsive thoughts or behaviors
		Eyes			
____	____	Change in vision	____	____	Anxiety/ panic
			____	____	Depressed mood
		Integumentary (Skin/Breast)	____	____	Suicidal thoughts
____	____	Rashes or itching	____	____	Overwhelming stress at home, work, or in relationships
____	____	Change in skin color or moles			
____	____	Change in hair or nails			
____	____	Breast pain, lump, or discharge			

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Yes	No		Yes	No	
		Ear/Nose/Mouth/Throat/Neck			**Neurological**
____	____	Hearing loss or ringing in ears	____	____	Frequent, recurring or increasing headaches
____	____	Earaches or drainage	____	____	Light-headedness or dizziness
____	____	Chronic sinus problems or runny nose	____	____	Convulsions, seizures or spasms
____	____	Nose bleeds	____	____	Numbness or tingling sensations
____	____	Mouth sores	____	____	Tremors
____	____	Bleeding gums	____	____	Paralysis
____	____	Sore throat/hoarseness or voice change	____	____	Head injury
____	____	Difficulty swallowing			
					Endocrine
		Cardiovascular	____	____	Heat or cold intolerance
____	____	Heart trouble	____	____	Excessive skin dryness or sweating
____	____	Chest pain or angina pectoris	____	____	Excessive thirst or urination
____	____	Palpitations	____	____	Woken at night by the need to urinate
____	____	Shortness of breath with walking or lying flat			
____	____	Swelling of feet, ankles or hands			**Musculoskeletal**
			____	____	Joint pain(s)
		Respiratory	____	____	Joint stiffness/swelling or warmth
____	____	Chronic or frequent cough	____	____	Muscle pain or recurrent cramps
____	____	Coughing or spitting up blood	____	____	Back pain
____	____	Shortness of breath	____	____	Cold hands or feet
____	____	Asthma or recurrent wheezing	____	____	Difficulty in walking
					Hematologic/Lymphatic
		Gastrointestinal	____	____	Slow to heal after cuts or wounds
____	____	Loss of appetite	____	____	Bleeding or bruising tendency
____	____	Change in bowel movements	____	____	Recurrent anemia
____	____	Nausea or vomiting			
____	____	Painful bowel movements or constipation			
____	____	Frequent diarrhea			
____	____	Rectal bleeding or blood in stool			
____	____	Stomach/abdominal pains or heartburn			
____	____	Black or tarry stools			
		Genitourinary			
____	____	Frequent urination			
____	____	Burning or pain on urination			
____	____	Blood in urine			
____	____	Change in force/strain when urinating			
____	____	Incontinence or dribbling of urine			
____	____	Sexual difficulties			
____	____	Men: Testicular Pain			
____	____	Women: Painful periods			
____	____	Irregular periods			

No. of pregnancies (including miscarriages):_____

_____#Deliveries #Miscarriages_____

Method of birth control:_____

Date of last pap smear:_____

If Menopausal, since when:_____

Date of last mammogram:_____

Comments: _____

_____

_____

_____

_____

_____

_____