Total Family Care

Affiliated with Lawrence Memorial Hospital

New Patient Questionnaire

Date _____ Name _____

Date of Birth _____ Age _____

Do you have an Advance Directive or other legal, healthcare document?

□ Yes (please provide copy) □ No, but I would like additional information

□ No, and I do not want further information

Drug Allergies _____

Other Allergies _____

What are you health goals for the next year? _____

Where were you getting your care before? _____

Have you been to the Emergency Room in the past 6 months? □Yes □No How many times? _____

Have you stayed overnight in the hospital in the past 12 months? □Yes □No How many times? _____

Have you been in a Skilled Nursing Facility in the past 12 months? □Yes □No How many times? _____

CURRENT MEDICATIONS: including over-the-counter and herbal

Medication	Dose	Frequency
1)		
2)		
3)		
4)		
5)		
6)		
7)		

Are there any of your current medications that you do not understand or have questions about? □Yes □ No

Are there any barriers to you taking your medications as prescribed? □Yes □No

Pharmacy Name/Location: _____

Reason for today's visit: _____

Other concerns or health-related goals I want to address (may need to occur at future visit): _____

_____

The following item(s) apply to today's visit (mark all that apply):

□ I need med refills

□ I need a referral to a specialist

□ I need a note for school/work

□ I have a form I need filled out

□ I need lab work done

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

MEDICAL HISTORY

When was your last:

Cholesterol check? _____

Colonoscopy? _____

Eye exam? _____

Dental Exam? _____

Please complete reverse side

Name _____

Please check if you currently have or have had any of the following:

□ Anxiety □ Diabetes □ Heart disease
□ Asthma □ Depression □ High blood pressure
□ COPD/Emphysema □ Cancer: _____ □ High cholesterol

Other medical problems not listed: _____
_____

When was your last colonoscopy? _____
Hospitalizations you have had with date/reason:
1) _____
2) _____

Female Only:
Date last period began _____ If you do not have periods, when did they stop? _____
Age of first period _____ Current method of birth control _____
When was your last Pap? _____Have you ever had an abnormal Pap? □Yes □ No
Treatment/year for abnormal Pap: _____
Number of times pregnant _____ Miscarriages _____Abortions _____Births _____
Ages of Children _____ Are you considering pregnancy in the next year? □ Yes □ No
Have you ever had a mammogram? □ Yes □ No If yes, when/where? _____

Male Only:
Date of Last PSA? _____
□ Concerns about erectile dysfunction
□ Changes in urination
□ Other: _____

FAMILY MEDICAL HISTORY

(Indicate health issues of the following family member, such as cancer, heart disease, high blood pressure, mental illness, allergies, arthritis, diabetes, or any other health concerns.)

Mother: _____ **Maternal Grandmother: _____**

Father: _____ **Paternal Grandmother: _____**

Sibling: _____ **Maternal Grandfather: _____**

Sibling: _____ **Paternal Grandfather: _____**

SURGICAL PROCEDURES:

1)_____

2)_____

3)_____

4)_____

SOCIAL HISTORY

□ Single □ Married □ Divorced □ Widowed □ Single but in long term relationship
Are you currently sexually active? □ Yes □ No New partners since last exam? □ Yes □ No
Are you interested in getting tested for sexually transmitted diseases? □ Yes □ No
Previous sexually transmitted infection? □ Yes □ No If yes, what kind? _____
What is your current occupation? _____
Do you smoke? □ Yes □ No If yes, how much? _____
If no, did you ever smoke? □ Yes □ No If yes, how much & when did you quit? _____

Name _____

How often do you use alcohol? □ Never □ Rarely □ 2-3 times/month □ 2-3 times/week □ Daily
Average number of drinks per episode: _____ Do you drink caffeine? □ Yes □ No How much_____
Do you use any recreational or illicit drugs? □ Yes □ No If yes, what kind? _____
Do you exercise? □ Yes □ No If yes, how often & what type? _____
Do you use seatbelts? □ Yes □ No If motorcycle rider, do your wear a helmet? □ Yes □ No □ N/A
Current sources of stress in your life: _____

Special diet: _____

Please circle if you are having any of the following problems:
Constitutional: [Fever] [Chills] [Sweats][Weakness] [Fatigue] [Decreased Activity]
Eyes: [Recent visual problems] [Discharge] [blurring] [Double Vision] [Visual disturbances]
ENT: [Decreased hearing] [Ear pain] [Nasal congestion] [Sore throat]
Respiratory: [Shortness of breath] [Cough] [Sputum production] [Coughing up blood] [Wheezing] [Apnea]
Cardiovascular: [Chest pain] [Palpitations][Slow heart rate] [Fast heart rate] [Swelling] [Fainting]
Gastrointestinal: [Nausea] [Vomiting] [Diarrhea] [Constipation] [Heartburn] [Abdominal pain] [Vomiting blood]
Genitourinary: [Pain with urination] [Blood in urine] [Change in urine stream] [Urethral discharge] [Lesions]
Gynecologic: [Painful periods] [Hot flashes] [Intermenstrual bleeding]
Hema/Lymph: [Bruising tendency] [Bleeding tendency] [Swollen lymph glands]
Endocrine: [Excessive thirst] [Frequent urination] [Cold intolerance] [Heat intolerance] [Excessive hunger]
Immunologic: [Immunocompromised] [Recurrent fevers] [Recurrent infections] [General discomfort]
Musculoskeletal: [Back pain] [Neck pain] [Joint pain] [Muscle pain] [Lower leg pain] [Decreased range of motion] [Trauma]
Skin: [Rash] [Itching] [Abrasions] [Sores] [Burns] [Dryness] [Broken blood vessels] [Skin lesion] [Raised scar]
Neurologic: [Abnormal balance] [Confusion] [Numbness] [Tingling] [Headache]
Psych: [Anxiety] [Depression] [Mania] [Suicidal] [Delusional] [Hallucinations]

Other items not mentioned above: _____

VACCINATIONS

Please check if you have received the following vaccines and indicate approximate dates.

□ Tetanus Date: _____
□ Pneumonia Date: _____
□ Shingles Date: _____
□ HPV (series of 3) Date: _____
□ Hepatitis A (series of 2) Date: _____
□ Hepatitis B (series of 3) Date: _____
□ Meningitis Date: _____
□ Chicken pox (varicella) Date: _____
□Had the disease Date: _____
□ Influenza Date: _____

We are happy to request medical records from other medical providers for documentation purposes.