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New Patient Health History

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**
Previous or referring doctor:	**Date of last physical exam:**	
Job Title:		
Pharmacy Name:	**Pharmacy Phone Number:**	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

Screenings	**Date**	
☐ Colonoscopy		
☐ TIT/Stool Test		
☐ Mammogram		
☐ Pap Smear		

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Type full name here to sign electronically

Patient Name:	**Date of Birth:**

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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers, herbal supplements

Name the Drug	Strength/Amount	Frequency Taken

Allergies to medications/seasonal/environment or N/A

Name the allergen	Reaction You Had

LIFESTYLE AND RESIDENCE INFORMATION			
Support:	Support Person #1:		
	Support Person #2:		
	Support Person #3:		
Religion:			
Have you Traveled outside the area?	☐ Yes ☐ No	If yes, where?	
Education (highest grade completed):			
Housing status:	☐ Not Homeless ☐ Doubling Up ☐ Shelter ☐ Street ☐ Transitional		
Do you have?	☐ Smoke detectors ☐ Firearms in the home		
Have you ever been a victim of abuse or domestic violence?	☐ **YES** ☐ **NO**		
Do you feel safe at home?	☐ **YES** ☐ **NO**	**Do you live alone?**	☐ **YES** ☐ **NO**

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HEALTH HABITS AND PERSONAL SAFETY

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Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol? ☐ Rarely ☐ Occasionally ☐ Socially				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to “binge” drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco? ☐ Rarely ☐ Occasionally ☐ Socially				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?				☐ Yes	☐ No
	May we have a copy if yes?				☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

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VISION QUESTIONNAIRE

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Are you currently wearing contacts?	☐ **YES** ☐ **NO**
Do you currently have prescription glasses?	☐ YES ☐ NO
Please list any eye disorders you have been diagnosed with	

RELEVANT FAMILY HEALTH HISTORY

☐ **NO RELEVANT FAMILY HISTORY** ☐ **ADOPTED**

	MOTHER	FATHER	BROTHER	SISTER	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANMOTHER	PATERNAL GRANDFATHER	AUNTS/ UNCLES
CANCER									
DIABETES									
HIGH BLOOD PRESSURE									
HEART ATTACK									
HEART DISEASE									
BLOOD CLOTS/ DVT									
STROKE									
MENTAL ILLNESS									
DRUG/ALCOHOL ADDICTION									
GLAUCOMA OR MACULAR DEGENERATION									
OTHER DISEASES NOT MENTIONED									
LIVING?									

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

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