Well Primary Care Comprehensive New Patient Questionnaire

Welcome to Well Primary Care. Thank you for taking the time to fill out this form regarding your health history as this will help guide me in caring for you.

Name:

What are your goals in joining this practice?

What are your biggest health concerns?

How would you rate your health? Excellent Good Fair Poor

Medications:
Please list all prescriptions and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc).
□ Check box if you do not take any prescription or over the counter medications.
□ Check box if you brought a list of your medications.

Medication	Dose (e.g. mg/pill)	How many times per day?

Allergies or intolerance to medication?

Medication	Reaction

Personal Medical History:

Condition	Now	Past	Comments

Personal Surgical History:

Procedure	Date	Comments

Hospitalizations:

Reason	Date	Comments

Family History:
Adopted? □ No □ Yes Family History unknown? □ No □ Yes

Relative	Age (if living)	Age/ Year of Death	Current Illness	Cause of Death
Mother				
Father				
Brother				
Sister				
Children				

Immunizations:
Enter year (if known) of any vaccinations you have had.
Tetanus (Td) _____ With Pertussis (Tdap) _____
Varicella (Chicken Pox) shot or illness _____
Pneumovax (pneumonia) _____ Prevnar 13 (pneumonia)_____
Influenza (flu shot) _____
Hepatitis A _____ Hepatitis B _____
MMR _____ Meningitis _____ HPV _____
Zostavax (shingles) _____ Shingrix (shingles) _____

Health Maintenance Screening Tests:
Lipid (cholesterol) Date _____ Result _____
Sigmoidoscopy or Colonoscopy (circle one) Date (year)_____Abnormal? □ No □ Yes
Polyp? □ No □ Yes

Women's Health History:
Age at beginning of periods (menstruation): _____
Age at end of periods (menopause/hysterectomy): _____ □ Not applicable
Do you have concerns about your periods or menopause you'd like to discuss? □ No □ Yes
If you are having periods, how often do they occur? Every _____ days. How long do they last? _____ days.
Total number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____
Number of abortions: _____

Mammogram Most recent date/where _____ Abnormal? □ No □ Yes
Pap Smear Most recent date/where _____ Abnormal? □ No □ Yes
Bone Density Test Most recent date/where _____ Abnormal? □ No □ Yes

Health Issues:
Tobacco Use:
Smoke or smoked cigarettes/ pipe/ cigars (circle)? □ Never □ Yes
Exposure to secondhand smoke? □ No □ Yes
(If never used any tobacco can skip to Alcohol Use section below)
Current smoker: Packs/day: _____ # of years: _____
Former smoker: Quit date: _____
Approximately how many packs/day did you smoke? _____
How many years did you smoke? _____
Other tobacco? (circle) Snuff or Chew Currently use? □ Yes
Are you ready to quit? □ No □ Yes

Alcohol Use:
Do you drink alcohol? □ No □ Yes
# of drinks/week: _____ □ Beer □ Wine □ Liquor
How many times in a year have you had >3 drinks (for women) >4 drinks (for men) in a day?
_____

Drug Use:
Have you ever used recreational drugs? □ No □ Yes
If yes, which ones? _____
Quit which ones? □ All _____
Any used currently? _____

Safety:
Does your home have a working smoke detector? □ No □ Yes
Do you have guns in your home? □ No □ Yes
If yes, are they locked up & ammo stored separately? □ No □ Yes
Military Service? □ No □ Yes
History of Blood Transfusion? □ No □ Yes
Exposure to toxic chemicals at work? □ No □ Yes
Exposure to toxic chemicals doing hobbies? □ No □ Yes
Do you use a helmet for recreational activities? (e.g. bike, skateboard, ski)
□ Not applicable □ Yes □ No
Do you use seatbelts consistently? □ No □ Yes

Sexual Activity:
Are you sexually involved: □ Not currently □ Never □ Yes
Sexual partner(s) is/are/have been/may be in future: □ male □ female
Birth control method or STD prevention (check all that apply): □ None needed □ Condom □ Pill □ IUD □ Patch □ Ring □ Diaphragm □ Vasectomy □ Tubal ligation □ Other method (specify):_____

Diet:
Do you follow a special diet? Vegetarian Vegan Gluten Free Paleo Other

Exercise:
Do you exercise regularly? □ No □ Yes
If yes, what kind of exercise? _____
How long (minutes)? _____ How often? _____

Mental Health:
In the past 2 weeks: Have you been feeling down, depressed or hopeless? □ No □ Yes
Do you have little interest or pleasure in doing things?□ No □ Yes
Have you or any family members ever been hurt, insulted, threatened or screamed at, or physically abused? □ No □ Yes

Socioeconomic:
Occupation (or prior occupation): _____
Employer: _____
If you are not currently working, you are: □ retired □ unemployed □ on a leave of absence
□ disabled □ homemaker □ other _____
Marital status: □ single □ partner □ married □ divorced □ widowed
Spouse/partner's name: _____
Number of children: _____ Ages (if minors): _____
# of grandchildren: _____ # of great grandchildren: _____
Education: □ high school or GED □ trade school □ college □ graduate school □ other
Who lives at home with you: □ No one □ Spouse/partner □ Children
□ Pets (what type) _____
□ Other (roommates, extended family, etc) _____
Please list your interests, hobbies, group involvement, volunteer work, and/or travel outside of country in the past 6 months _____

Thank you for taking the time to fill out this form.
I look forward to working with you!