GUADALUPE FAMILY HEALTH, PA

COMPREHENSIVE ADULT NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Please fill out completely and bring to your first appointment, email, or fax. Please bring all medication bottles, ID, and insurance card.

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update form you should use instead. Please try to fill in all questions, it is long because it is comprehensive and we will only ask you to do it once so we can get to know you well enough to properly care for you. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

NAME: _____ **DATE:** _____

How did you learn about our practice? Circle one: Patient Family Member Physician Assigned Other/Name: _____

Main reason for today's visit: _____

Other concerns: _____

_____

What are your health goals for the next year? _____

How would you rate your health? (circle one) Excellent / Good / Fair / Poor

Please list healthcare providers and their specialty you see regularly: _____

_____

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications:

☐ Check box if you do not take any prescription or over the counter medications

☐ Check box if you brought a list of your medications (please give it to us and don't write in medications below)

Medication	Dose (mg)	How many times per day?

Allergies to medications? _____

IMMUNIZATIONS: If you have an immunization record, please give it to us.

HEALTH MAINTENANCE SCREENING TESTS:

Colonoscopy or fecal blood test: Date (year)_____ Polyp/Abnormal? ☐ Yes ☐ No

Women Only:

Mammogram Most Recent Date _____ Abnormal? ☐ Yes ☐ No

Pap Smear Most Recent Date _____ Abnormal? ☐ Yes ☐ No

Bone Density Test Most Recent Date _____ Abnormal? ☐ Yes ☐ No

PERSONAL MEDICAL HISTORY: Do you have now or have you had (in the past) any of the following conditions?

Condition	Now	Past	Comments
Alcohol / Drug Abuse			
Allergies (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Osteoarthritis or Rheumatoid)			
Asthma			
Bladder / Kidney Problems			
Blood Clots			
Breast Lump (benign)			
Cancer - List type in Comments			
Cataracts			
Chicken Pox			
Coronary Artery Disease			
Depression			
Diabetes			
Diverticulosis			
Emphysema / COPD			
Endometriosis			
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn)			
Glaucoma			
Gout			
Heart Attack			
Hepatitis			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Liver Disease			
Migraine Headaches / Chronic Headache			
Osteoporosis			
Pneumonia			
Prostate Enlargement			
Seizure			
Skin Conditions (Eczema, for example)			
Other (list)			
Other (list)			

SURGICAL & PROCEDURE HISTORY: Please check off any procedures or surgeries with the year if recalled.

Surgical Procedure	✓	Year
Abdominal Surgery		
Angiogram (heart)		
Angiogram (leg or other arteries)		
Appendectomy (appendix removal)		
Back or Neck surgery		
Breast or other Biopsy		
Breast surgery		
Cataract surgery		
Cervix surgery or biopsy		
Coronary (heart) bypass		
Coronary (heart) stent		
C-Section		
EGD (stomach endoscopy)		
Gallbladder Removal		

Surgical Procedure (cont.)	✓	Year
Hip Surgery (repair/replacement)		
Hysterectomy (total, include ovaries)		
Hysterectomy (partial, ovaries left)		
Knee Surgery (repair/replacement)		
Ovary Removal		
Sinus Surgery		
Stress Test (treadmill or otherwise)		
Tonsillectomy		
Tubal ligation		
Vasectomy		
Other		
Other		
Other		

FAMILY HISTORY: If adopted or if you do not know your family history skip this section and continue to Health Issues. Indicate which relative has had the following problems. If there is pertinent info such as whether the condition was fatal, please include it in the **Details** section.

Diseases	Mother	Father	Siblings	Grand-mother	Grand-father	Details: multiple siblings, fatal, etc.
Hypertension						
High Cholesterol						
Heart Attack, stent or bypass						
Diabetes (type if known)						
Stroke						
Cancer of Breast						
Cancer of Color						
Cancer of Prostate						
Cancer of Other (type?)						
Osteoporosis						
Depression						
Alcoholism / Drug Abuse						
Alzheimers / Dementia						
Asthma						
Autoimmune Disease						
Leg or Lung Clot						
Colon Polyp						
Emphysema (COPD)						
Liver failure / Cirrhosis						
Kidney Failure / Dialysis						
Thyroid Disease						
Parkinsons Disease						
Other (list)						
Other (list)						

HEALTH ISSUES:

Tobacco Use:

Smoke or smoked ☐ Yes ☐ No

Exposure to second hand smoke? ☐ Yes ☐ No

(If never used any tobacco can skip to **Alcohol**)

Current smoker: Packs/Day: _____ # of years _____

Former smoker: _____ Quit Date: _____

About how many packs/day did you smoke? _____

About how many years did you smoke? _____

Other Tobacco/Nicotine? (circle) Snuff Chew Vape

Quit Date: _____ Currently use? ☐ Yes ☐ No

Are you ready to quit? ☐ Yes ☐ No

Alcohol Use:

Do you drink alcohol ☐ Yes ☐ No

drinks/week: _____ ☐ Beer ☐ Wine ☐ Liquor

Drug Use:

Have you ever used recreational drugs? ☐ Yes ☐ No

If yes, which ones? _____

Quit which ones? _____

Occupational Risks / Exposures:

Military Service? ☐ Yes ☐ No

Blood Transfusion? ☐ Yes ☐ No

Exposure to toxic chemicals at work? ☐ Yes ☐ No

Exposure to breathing dust/particles? ☐ Yes ☐ No

Sexual Activity:

Are you sexually active? ☐ Not now ☐ Never ☐ Yes

Have you ever had a sexually transmitted infection? ☐ Yes ☐ No

Birth control method or STD prevention (check current)

☐ Not needed ☐ Condom ☐ Pill ☐ IUD ☐ Patch

☐ Ring ☐ Vasectomy ☐ Tubes Tied / Hysterectomy

☐ Rhythm Method/Periodic Abstinence

Exercise:

Do you exercise regularly? ☐ Yes ☐ No

If yes, what kind of exercise? _____

How long (minutes)? _____

How often? _____

Diet:

Do you follow a special diet? ☐ Yes ☐ No

If yes, which one? (circle) Vegetarian Vegan

Gluten Free Other _____

Mood:

Over the last 2 weeks how often have you been bothered by the following problems?	Not at all	Several Days	More than ½ of the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				

SOCIAL DOCUMENTATION:

Occupation (or prior occupation)_____ Employer: _____

If you are not currently working are you:

☐ 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: _____

SOCIOECONOMIC:

Occupation (or prior occupation)_____ Employer: _____

If you are not currently working are you:

☐ 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: _____

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____

Age at end of periods (menopause/hysterectomy): _____ ☐ Not applicable

Do you have concerns about your periods or menopause you'd like to discuss? ☐ Yes ☐ No

_____

If you are still having periods, how often do they occur? Every _____ days. How long do they last? _____

Thank you for taking the time to complete this form!