

PATIENT NAME IN FULL

M
 F

MEDICAL RECORD NUMBER

DATE OF BIRTH

PERSONAL AND FAMILY HISTORY

Please check the appropriate column if YOU or any of your IMMEDIATE RELATIVES (parents, children, brothers or sisters) had any of these conditions:

CONDITION	YOURSELF	FAMILY MEMBER
Heart attack, coronary bypass surgery, abnormal treadmill test or stent placement		
Aneurysms		
High blood pressure		
Blood clots		
Strokes		
High cholesterol		
Hemachromatosis or iron-storage disorders		
Bleeding or hemophilia		
Sickle cell anemia or thalassemia		
Breast cancer		
Prostate cancer		
Colon cancer		
Any other cancer, lymphoma, leukemia, etc.		
Cervical or ovarian cancer - <i>specify which</i>		
Cancer of the skin of any type		
Diabetes		
Hepatitis (<i>if so, specify what type: A, B, C, other?</i>)		
Epilepsy or seizure disorder		
HIV positive or AIDS		
Migraines		
Thyroid trouble		
Birth defects		
Any other disorder which may be inherited, <i>specify:</i>		
Early or sudden death		
Asthma		
Hay fever, pollen or ragweed type allergies		
Chronic bronchitis or emphysema		
Abnormal chest X-ray		
Sleep apnea		
Tuberculosis		
Osteoporosis or age-related loss of height		
Rheumatoid arthritis or lupus		
Gout		
Polycystic kidneys		
Kidney stones		
Kidney failure		
Bleeding ulcers or stomach ulcers		
Colitis or inflammatory bowel disease		
Colon polyps		
Hormone replacement therapy		
Miscarriages		
Positive test for syphilis or STD (herpes, warts, gonorrhea or other)		
Attention-deficit disorder		
Chemical dependence or substance abuse		
Alcohol addiction or other alcohol problems		
Schizophrenia		
Bipolar disorder		
Depression requiring counselling or treatment		
Obesity		

PHYSICIAN'S INITIALS

NEW PATIENT COMPREHENSIVE HISTORY QUESTIONNAIRE 987-991 page 3 of 4 / 09-05

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SURGICAL OPERATIONS YOU HAVE HAD IN THE PAST

✓	SURGERY	WHO DID THE SURGERY or WHERE IT WAS PERFORMED	YEAR
	Gallbladder surgery		
	Appendectomy		
	Hernia (which side?)		
	Hysterectomy		
	Removal one or both ovaries		
	Implant surgery		
	Spine surgery (back or neck)		
	Hip or knee surgery		
	Vasectomy or tubal ligation		
	Cataract surgery		
	Cancer surgery (specify which type)		

HOSPITALIZATIONS FOR REASONS OTHER THAN SURGERY

REASON FOR HOSPITALIZATION	YEAR	REASON FOR HOSPITALIZATION	YEAR

MAJOR INJURIES ~ Include Any Head Trauma and Fractures

TYPE OF INJURY	WHERE IT WAS TREATED	COMPLICATIONS	YEAR

ALLERGIES AND REACTIONS TO MEDICATIONS

Please list any allergic reactions or other adverse reactions you have had to any medications, including over-the-counter medications. Please specify what kind of reaction you had. (If you have had a reaction to penicillin, did it involve collapsing, difficulty breathing or did it occur in less than an hour after taking penicillin?)

Please check this box if you have had no medication allergies or reactions.

ALLERGIES AND REACTIONS TO FOODS, LATEX, BEE STINGS, BITES, OR SUBSTANCES OTHER THAN MEDICATIONS

Please write down any reactions or allergies you have had to things other than medications. Please specify what kind of reactions you have had.

NAME OR TYPE OF SUBSTANCE	KIND OF REACTION	SEVERE (YES OR NO)	YEAR

VACCINATIONS

VACCINE	YES	NO	YEAR	VACCINE	YES	NO	YEAR
Hepatitis A				Typhoid			
Hepatitis B				Yellow Fever			
Pneumonia				Measles, mumps, rubella			
Polio				Small pox			
Tetanus				Yearly flu shot			
Chickenpox (varicella)				Other			
Meningococcal				Other			

PHYSICIAN'S INITIALS

PATIENT NAME IN FULL _____	<input type="checkbox"/> M <input type="checkbox"/> F	MEDICAL RECORD NUMBER _____	DATE OF BIRTH _____
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YOUR HOME AND YOUR SOCIAL SYSTEMS

Do you live in an apartment or other multiple-family dwelling? No Yes

Do you live by yourself? No Yes

Are you Married Single Divorced Widowed In a Civil Union (check one)

Do you keep guns in the home? No Yes

If so, are they locked where others can not get at them? Yes No

Do you have a smoke alarm in your home or apartment? Yes No

If you have a smoke alarm, have you tested it within the last six months? Yes No

Have you done a home safety check in the last six months? Yes No

Do you have stairs in the home? No Yes

Would you be interested in learning about an alert device in case you fall? No Yes

Do you have a living will? Yes No

(Optional) Do you have a religious preference? No Yes, *specify* _____

In case of illness, would you have help and emotional support available, either through family, friends, place of worship, or other organization? No Yes

Do you have financial stresses that might keep you from being able to get prescriptions filled or necessary medical care Yes No

List any international travel within the past three years including military. _____

SOCIAL AND ENVIRONMENTAL

Do you ride motorcycles or bicycles? (check which) No Yes

If so, do you wear a helmet? Yes No

Do you regularly wear shoulder belts in your car? Yes No

Do you exercise regularly? Yes No

If so, what do you do? _____

Do you use tobacco, including cigarettes, cigars, pipes, chewing tobacco, snuff or other forms of tobacco? No Yes

If so, what type and how many times per day (for cigarettes, packs per day)? _____

How long have you used tobacco products? _____

If you previously used tobacco, how long did you do that and when did you quit? _____

Are you exposed to secondhand smoke at home or work? No Yes

Have you had any recent tick bite? No Yes

Do you have municipal water supply where you live Yes No

Do you have a pet at home? No Yes, *what type* _____

What is your occupation? _____

What are your hobbies or outside interests? _____

Do you have any health risks at work (chemicals, airborne dusts or vapors, excessive noise? No Yes

If yes, please list: _____

Do you operate dangerous moving machinery or commercial vehicles including buses, airplanes, or trucks? No Yes

Do you use alcohol, including distilled spirits such as liquor, wine, beer or other types? (circle one or more) No Yes

If so, how much do you use in a typical day (in ounces)? _____ in a typical week? _____

Do you drink fairly heavily some days of the week? No Yes

How about binge drinking or more than usual drinking on the weekends? No Yes

Do you drink coffee, tea or other beverages with caffeine including soft drinks? No Yes

If so, do you drink more than three such beverages in a day? No Yes

Have you been abused physically or emotionally, including being hit or threatened? No Yes

This is a list of certain activities and behaviors that can increase the risk of a person contracting certain conditions.

Check this box if you should discuss any of these with your doctor or provider.

- | | |
|---|---|
| <ul style="list-style-type: none"> Having any body piercing Having more than five lifetime sexual partners Men, having sex with other men Having any needlestick accidents Having anal intercourse | <ul style="list-style-type: none"> Ever using intravenous or street drugs Paying for or having been paid for having sex First sexual intercourse before age 17 Not taking precautions about sexually transmitted diseases Having any tattoos |
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ADDITIONAL COMMENTS

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PHYSICIAN'S SIGNATURE _____	DATE _____
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