

NEW PATIENT HEALTH QUESTIONNAIRE

Welcome to our multidisciplinary family practice!

Please take a moment to complete this form to the best of your knowledge and bring back to the office. All information below will be treated in a strictly confidential manner. If enrolled into the practice, it will become part of your medical record and will help our doctors, nurse practitioners and our team to provide you with the best health care possible.

Today's date: _____

I. Patient Information

Name: _____ Sex: M F

Date of birth: (mm/dd/yyyy): _____

Marital status: Married, Single, Divorced, Separated, Other (*please circle*)

Address: _____ Home phone: _____

_____ Work: _____

_____ Mobile: _____

Health card # _____ Previous Doctor: _____

Emergency contacts

Name: _____ Relationship: _____ Phone: _____

Do you have a Do Not Resuscitate Order (DNR)? Power of Attorney for Personal Care?

II. Medical History

Allergies (medications, food, seasonal/environmental, latex, other):

Allergic to: _____ Reaction: _____

Current Health Concerns (e.g., high blood pressure, pain, low mood)

Past Medical History *(please include year of diagnosis)*

Heart conditions _____
(e.g., chest pain, heart attack, high blood pressure, high cholesterol, irregular heart beat)

Lung conditions _____
(e.g., asthma, emphysema/COPD, sleep apnea, lung cancer)

Blood disorders _____
(e.g., anemia, blood clots, hemophilia, blood cancer)

Stomach/bowel _____
(e.g., heartburn, ulcers, Crohn's disease, constipation, bleeding, cancer)

Endocrine conditions _____
(e.g., thyroid disease, diabetes)

Nervous system disease _____
(e.g., migraines, seizures, stroke, memory loss, blackouts)

Infections _____
(e.g., HIV/AIDS, hepatitis, meningitis, tuberculosis, sexually transmitted infections)

Mental health _____
(e.g., depression, anxiety, psychosis, bipolar disease, suicidal thoughts, alcohol abuse)

Other _____

(e.g., cancer, arthritis, fractures, osteoporosis, irregular periods, erectile dysfunction)

Past Surgeries or Hospitalizations *(please include year and reason for hospitalization)*

1. _____
2. _____
3. _____
4. _____

Pregnancy History and Women's Health *(for females only)*

Pregnancies ____ # Deliveries: vaginal ____ c-section ____ # Miscarriages ____ # Abortions ____

Date of last Pap smear _____ Date of last mammogram _____

Last bone density test _____ Date of last full physical _____

Medications *(including prescription, vitamin and herbal supplements)*

Medication	Dose, mg	Times per day	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History of *(record relationship: mother, father, sister/brother, grandparents, children)*

Heart attack _____ Stroke _____
Diabetes _____ High blood pressure _____
High cholesterol _____ Seizures _____
Dementia _____ Psychiatric conditions _____
Cancer *(specify type)* _____
Other _____

Social history

Occupation _____
Do you smoke? Yes Quit (year) ____ No **If Yes** Cigarettes Cigars Pipe *(circle)*
How many cigarettes/packs a day? _____
How many years? _____ # quit attempts _____
Do you drink alcohol? Yes No **If Yes**, # of drinks per week _____
Have you ever used recreational drugs? Yes No **If Yes**, which drugs _____
Do you have a special diet? _____

Immunizations history: please bring your immunization records to your first appointment

Current medical specialists *(please include name, type of specialist and date of last visit)*

Please provide any other relevant information _____

Thank you,
Charing Cross Medical team