Name:_____DOB:_____Date:_____

Comprehensive Adult New Patient Health History Questionnaire

Answers on this form will help your doctor get an accurate history of your medical concerns and conditions. Please fill in all the pages. It is long because it is comprehensive. We really want to know you well so we can 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

Who referred you to my practice?
Circle one: patient family member physician other:_____
Main reason to establish care today?_____
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:_____
_____
_____
List any medical suppliers you use (e.g. supplies):_____

MEDICATIONS: Please list all prescriptions and non-prescription medications. Includes vitamins, herbs, supplements, birth control pills, inhalers, over the counter medications.

Medication	Dose	How many times per day

ALLERGIES or intolerance to medications? YES NO
(if yes, to what and what reaction?)_____

IMMUNIZATIONS: (enter the year of any you had)
Tetanus (Td)_____ With Pertussis(Tdap)_____ Varicella (Chicken Pox) shot or illness_____ Pneumovax (pneumonia)_____
Influenza (flu shot)_____ Hepatitis A_____ Hepatitis B_____ MMR_____ Meningitiis_____ Zostavax (shingles)_____ HPV_____
Men only:
How many time do you get up to urinate: _____
Do you experience any decreased stream or dribbling:_____
Do you have trouble getting erections:_____
Women Only:
Mammogram: Most recent date/where:_____ Abnormal? YES NO
Pap Smear: Most recent date/where:_____ Abnormal? YES NO
Bone Density Test Most recent date/where:_____ Abnormal? YES NO
Age at beginning periods (menstration) _____
Age at end of periods (menopause/hysterectomy)_____

LAST COLONOSCOPY: Date:_____ Where:_____

Surgical Procedures:

Date	Procedure	Physician	Hospital	Notes

Alamo Heights PRIMARY CARE PHYSICIANS

Name:_____DOB:_____Date:_____

Major Illness:

Illness	Start Date	End Date	Physician	Treatment Note

Currently have or Been treated for:

Yes	No	Condition	Explain
		Asthma	
		Bleeding Disorders	
		Blood Pressure	
		COPD	
		Diabetes	
		Ear/sinus	
		Fainting	
		Gastro-intestinal Problems	
		Heart disease	
		Kidney disease	
		Learning disorders	
		Menstrual problems	
		Musculo-skeletal	
		Psychological/psychiatric	
		Seizures	
		Sickle cell disease	
		Sleep disorders	
		Stroke	
		Surgery	
		Thyroid disease	
		Serious injury	
		Other	

Health Issues:

Tobacco Use:
Smoke or smoked Cigarettes/ Pipe/ Cigars (circle one)?
Never Yes
Current Smoker: Packs/day:_____ # of years:_____
Former Smoker: Quit date:_____
Approximately how many packs/day:_____
How many years did you smoke:_____
Other tobacco:_____
Are you ready to quit?_____

Alcohol Use:
Do you drink alcohol? Yes No (circle one)
# of drinks/week:_____ Beer Wine Liquor (circle)

Drug Use:
Have you EVER used recreational drugs? Yes No (circle one)
If yes, what ones?_____
Quit which ones?_____
Any used currently?_____

Social Activity:
Are you sexually involved: Not currently Never Yes (circle one)
Birth control method or STD prevention (circle all that apply)
-None needed -condom -pill -IUD -Patch -Ring -Diaphragm
-Vasectomy -Tubal ligation -Other method_____

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

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

In the past 2 weeks: Have you been feeling down, depressed or hopeless? Yes No (circle one)

Do you have little interest or pleasure in doing things? Yes or No

Medical Forms:
Please check any of the following forms you have completed:

- o Advance Directive for Health Care (ADHC)
- o Durable Power of Attorney (DPA) for healthcare decisions
- o Living Will
- o POLST (Physician Orders for Life Sustaining Therapy)
- o I know about these or have the forms but have no completed them
- o Don't know what these forms are