

Churchville-Chili Family Medicine New Patient Questionnaire

Patient Name: _____ **Date:** _____

1. Do you have any major health concerns today? Yes _____ No _____

If yes, please explain: _____

2. Please list all serious illnesses you have had and the date of onset:

Condition:

Date:

3. Please list all surgeries or serious injuries and dates:

Surgeries/Injuries:

Date:

4. Please list all medications and dosages, including over the counter meds:

5. Have you ever had an allergy or side effect to any drug or treatment?

Yes _____ No _____

Name of Drug(s):

Reaction:

6. Please list the date of your last immunizations, tests, or examinations:

Complete physical examination: _____

Diphtheria/Tetanus vaccination: _____

Pneumovax: _____

Females only: Pap smear _____

Mammogram _____

7. Are you currently a smoker? Yes _____ No _____

Have you ever smoked? Yes _____ No _____

If so, how old were you when you started smoking? _____

How many packs per day do you smoke? _____/per day

If you have quit smoking, how old were you when you quit? _____

8. Do you drink alcohol? Yes _____ No _____

If so, how many alcoholic beverages do you consume in a typical week?

0-2 _____ 3-5 _____ 6-8 _____ 9-12 _____ 13-15 _____ 16+ _____

9. Do you perform regular exercise? Yes _____ No _____

10. Do you have a spiritual belief system? Yes _____ No _____

If so, please describe: _____

11. Are you experiencing any symptoms you would like to discuss today?

12. Have you had any of the following?

	Yes	No
Change in wart or mole or new skin lesion?		
Severe headaches or new headaches?		
Vision problem or eye pain?		
Bad teeth?		
Hay fever or sinus trouble?		
Hearing problems?		
Cough?		
Shortness of breath?		
Wheezing?		
Hoarseness?		
Chest pain or pressure?		
Rapid or irregular heartbeat?		
Swollen ankles?		
Frequent stomach pains?		
Persistent or frequent nausea?		
Frequent vomiting?		
Constipation?		
Persistent diarrhea?		
Bloody or black stools?		
Recent change in bowel habits or stool size?		
Change in weight or appetite?		
Bladder or kidney infections?		
Difficulty passing urine or leaking of urine?		
Do you need to get up more than once at night to urinate?		
Joint pain, swelling, or redness?		
Numbness or tingling sensations?		
Dizziness or balance problems?		
Change in sleep patterns, or trouble sleeping?		
Severe anxiety or nervousness?		
Previous gonorrhea or syphilis (date)?		
Sores that do not heal?		
Testicular lumps or swelling?		
Irregular vaginal bleeding or discharge?		
Breast lumps or nipple discharge?		
Inability to find pleasure in life?		

13. Family Health: Please note if anyone in your family has had emphysema, diabetes (sugar), mental illness, glaucoma, heart disease, high blood pressure, stroke, cancer, TB, alcoholism, or any other major illness.

Relationship	Age	Health Problems	If deceased, age and cause of death:
Father			
Mother			
Spouse			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Brother(s)			
Sister(s)			
Children			