Alder Brook Family Health
NEW PATIENT QUESTIONAIRE,

Name: _____ Date of Birth: _____ Today's date: _____

1. Your typical Day and Health Habits

Circle what best describes your situation: Single, Married, Divorced, Widowed, Engaged, Partnership, Civil Union, Committed relationship

Relationships and ages of those living with you_____

Time you get up: _____ Time you go to bed: _____ Work hours: _____

Occupation: _____

Occupation of partner/spouse_____

Please describe your typical meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How many 8 oz servings of calcium rich foods (milk, cheese, yogurt) do you consume per day? _____

What do you do for exercise? _____

How many days per week? _____ How many hours per week? _____

What are your hobbies? _____

What else do you do for fun? _____

What religious social or community activities are you involved in? _____

1. Do you have a living will/ medical power of attorney? ---------- Y N

2. Do you always wear your seatbelt? ---------- Y N

3. Do you always wear a helmet when bicycling or motorcycling? ---------- Y N

4. How many cups of caffeinated coffee, tea or soda do you drink per day? _____
5. Do you smoke? ---------- Y N
   How many cigarettes per day? _____
   Did you smoke in the past? ---------- Y N
   When did you quit? _____
6. Do you chew tobacco? ---------- Y N
7. Do you drink alcohol? ---------- Y N
   If no skip to question 12
8. What is your average number of drinks per day? _____
   (1 drink = 1.5 oz liquor, 12 oz. beer, or 5 oz. wine)

9. Have you been concerned enough about your drinking to feel you should cut down? ----------Y N

10. Have you been annoyed by people's comments about your drinking? ---------- Y N

11. Have you ever felt guilty about your drinking? ---------- Y N

12. Have you had a drink first thing in the morning to steady your nerves or get rid of a hangover? ---------- Y N

13. Have you had a drink in the last 24 hours? ---------- Y N

14. Have you ever had an alcohol problem? ----------Y N

15. Do you use opiates, heroin, hallucinogens (such as LSD), cocaine or amphetamines (such as speed or crystal meth)? ---------- Y N
    Have you ever used these drugs in the past? ----------Y N
    Have you ever injected drugs? ----------Y N
16. Do you use marijuana? ----------Y N

MEDICAL HISTORY

Please list any known medical conditions (such as diabetes, high blood pressure, depression, etc…)

***Please list any past surgeries*:**

Surgery	Doctor/hospital	Date

Please list any other hospitalizations:

Reason for hospitalization	Doctor/hospital	Date

Immunization Questions

1. Date of last Tetanus Shot _____
2. Have you had 2 measles shots? ---------- Y N
3. Have you had a pneumonia vaccine? ---------- Y N
4. Have you had or been vaccinated against chickenpox? ---------- Y N
5. Are you exposed to blood or blood products?---------- Y N
6. Have you had your spleen removed?---------- Y N

MEDICATIONS: including prescription, over-the-counter, herbal. Add additional sheet if necessary:

Medication	*Dose*	*Reason prescribed*	*Doctor prescribing*

Drug allergies: (include latex and adhesive tape allergies, if present)

Medication	*Type of reaction*

Family History

Do you have a first-degree relative (parent, brother, sister, child) with:

	Y	N	relationship	age
a. heart attack, angina or heart surgery before age 60?				
b. breast cancer?----------				
c. colon cancer, rectal cancer or polyps?----------				
d. prostate cancer?----------				
e. ovarian cancer?----------				
f. diabetes or "sugar"?----------				
g. melanoma?----------				
h. glaucoma? ----------				
i. osteoporosis?----------				
j. high cholesterol?----------				
k. aortic aneurysm?----------				

Are there any other diseases that run in your family? Specify please_____

REVIEW OF SYSTEMS

Endocrine

Have you had:

1. a recent weight loss of ten pounds of more without changing your diet or exercise? ----- Y N
2. severe fatigue causing loss of work?----------Y N
3. a thyroid problem or operation----------Y N
4. diabetes----------Y N

Urinary

Have you had?

1. frequent urinary tract infections?-------Y N
2. a kidney stone? ----------Y N
3. blood in your urine?----------Y N
4. pain with urination?----------Y N
5. urgent need to urinate?----------Y N

Eyes, ears, nose, throat

Have you had:

1. failing vision not correctable by glasses?------Y N
2. trouble with your hearing?----------Y N
3. persistent pain or difficulty in swallowing?----Y N
4. persistent sore throats?----------Y N
5. Are you seeing an eye doctor for problems? ---Y N
6. frequent nosebleeds? ----------Y N

Skin

Have you had?

1. a changing skin mole?----------Y N
2. skin cancer?----------Y N
3. an unusual skin rash?----------Y N

Gastroenterology

Have you ever had?

1. vomiting of blood?----------Y N
2. frequent heartburn---------- Y N
3. bloody bowel movements?----------Y N
4. significant change in bowel movements?------Y N
5. an ulcer?----------Y N
6. diverticulitis or diverticulosis? ----------Y N
7. a polyp or tumor in the bowel?----------Y N
8. gallstones?----------Y N
10. if over 50, have you had a colonoscopy?--------Y N

Musculoskeletal

1. Have you had back pain which caused you to miss work? ----------Y N
2. Have you had pain and swelling in your joints making it difficult to function ?----------Y N
3. Have you ever suffered from gout?----------Y N

For Men Only

1. Have you had any urinary dribbling, frequent urination, difficulty starting or stopping urination?----Y N
2. Do you want to discuss any sexual problems?..--..Y N
3. Do you have sex with ? **Circle:** *Men Women Both*
4. Have you had a sexually transmitted disease? Gonorrhea, Chlamydia, Genital warts, Herpes, HIV, syphilis Y N

For Women Only

1. Date of last menstrual period: _____
2. Do you think you may be pregnant? ---------- Y N
3. What are you using for birth control? **Circle:** *birth control pills, IUD, Condoms, Nuvaring, Patch, Depo Shot, Tubes tied, partner had a vasectomy*
4. Have you been on hormone replacement?---------- Y N
5. Have you had vaginal bleeding after menopause? ----------Y N
6. Have you had bleeding between periods?----------Y N
7. Have you had an abnormal PAP smear?----------Y N
8. Do you want to discuss sexual problems?----------Y N
9. Have you had a sexually transmitted disease? (Gonorrhea, Syphilis, Herpes, Chlamydia, Genital warts, HIV) --- Y N
10. Do you have sex with ? **Circle:** *Men, Women, Both, Neither*
11. Have you had a new sexual partner since your last PAP smear?----------Y N

Cardiovascular/Respiratory

Have you had?

1. chest pain, heaviness or pressure?---------Y N
2. skipped or irregular heartbeats?----------Y N
3. breathlessness or cough that awakens you at night? ---------- Y N
4. high blood pressure?----------Y N
5. ankle swelling?----------Y N
6. shortness of breath with exertion?--------- Y N
7. calf pain with walking?---------- Y N
8. cough lasting longer than a usual cold? Y N
9. coughing up blood?---------- Y N
10. a positive TB test?----------Y N
11. high cholesterol or triglycerides ----Y N

Hematologic

Have you had?

1. a bleeding disorder or hemophilia?------- Y N
2. jaundice or liver disease?----------Y N
3. malaria?----------Y N
4. your spleen removed?----------Y N
5. anemia or low iron count----------Y N

Neurological

1. Are you regularly bothered by headaches that leave you unable to function or that are worsening?----------Y N
2. Have you ever had a stroke? ----------Y N
3. Have you had seizures?----------Y N
4. Do you have Multiple sclerosis---------Y N

12 Date of last PAP smear? _____
13. Date of last mammogram? _____
14. Have you had an abnormal mammogram?----------Y N
15. Would you like information on birth control?----------Y N
16. Have your periods been irregular?----------Y N
17. Did your mother take DES?----------Y N
18. How many pregnancies have you had?_____ Miscarriages?_____ Abortions?_____
19. Have you had a bone density test? Y N

Psychological

1.Are you have any problems with any of the following areas of your life that you'd like to discuss?
1. Relationships 2. Children
3. Extended family 4. Work

2. Are you recently divorced , separated, or widowed? ----------Y N
3. Have you had a death in the family in the past year? ---------- Y N
4. Have you been a victim of physical or sexual abuse? ----------Y N
5. Do you feel safe at home? ----------Y N
6. Have you had panic attacks? ----------Y N
7. Have you had nervous breakdown or been hospitalized for your nerves? ----------Y N
8. Have you attempted suicide? ----------Y N
9. Have you had a family member commit suicide? ---------- -Y N
10. Do you want counseling for any problems? ----------Y N

A note to patients: Depression is a highly treatable, very common condition in any primary care practice. It's important to screen for this disease. Please take the time to fill out this clinically proven depression scale.

Over the past 2 weeks, how often have you :	None or little	Some	Most of the	All of
(Check box that applies)	of the time	of the time	time	the time
1. been feeling low in energy, slowed down?				
2. been blaming yourself for things?				
3. had poor appetite?				
4. had difficulty falling asleep staying asleep?				
5. been feeling hopeless about the future?				
6. been feeling blue?				
7. been feeling no interest in things?				
8. had feelings of worthlessness?				
9. have thought about, or wanted to commit suicide?				
10. had difficulty concentrating or making decisions?				

Do you have any other problems to discuss with your provider? _____