New Health Care Consumer Questionnaire
Patient Name ________________________________ DOB ____/____/________ Date ____/____/________

In order to best serve your medical needs, we ask that you complete the following questionnaire as completely as possible. The ***Health Care Consumer (HCC) - Health Care Provider (HCP)*** *relationship is a privileged relationship built on trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false information may seriously and adversely affect your health.*

Patient Name ____ **Gender** ❑M ❑F
Last First Middle

Date of Birth (*MM/DD/YYYY*) _______/_______/___________ **Social Security Number** ______ - ______ - ________

If the person completing this form is not the patient, please write your name, your relationship to the patient, and why you are completing the form for this patient.

Name____________________________**Relationship**_________________**Reason**______________________

Reason For Visit ____

Patient's Personal Contact Information (Address and Phone)

_______________________________________ Home Phone _______________________________

_______________________________________ Work Phone _______________________________

Emergency Contact (Address and Phone)

_______________________________________ Home Phone _______________________________

_______________________________________ Work Phone _______________________________

Insurance Information (Insurance Company, Policy Number, Contact Number)

_______________________________________ Contact # _______________________________

Policy#________________________________ Fax (if known) _______________________________

Additional, or Secondary Insurance Company

_______________________________________ Contact # _______________________________

Policy#________________________________ Fax (if known)_______________________________

Have you completed a Living Will OR designated a Durable Power of Attorney for Health Care? ❑**Yes** ❑**No**
If yes, please provide a copy for your health care provider.

Do you have any religious or cultural beliefs that may impact your health care? ❑**Yes** ❑**No**
If yes, please describe
____

Methods of learning new material that I like best are:
❑Verbal Instruction ❑Written Instruction ❑Handouts ❑Visual (Pictures, Videos, etc)

❑ *You Do* ❑ *You Do Not* understand English well. The language you prefer ______________________

Level of education completed
❑<6th grade ❑6th – 8th grade ❑9th grade ❑12th grade ❑1-4 years college ❑>4 years college

Patient Name ________________________________ DOB ____/____/________ Date ____/____/________

Names and Phone Numbers for Health Care Providers (HCPs) from whom you are currently receiving care (or have seen within the past 12 months)**,** ***AND ANY*** **Health Care Providers from whom you are obtaining prescriptions.**

______________________________ Contact #__________________________

______________________________ Contact #__________________________

______________________________ Contact #__________________________

______________________________ Contact #__________________________

______________________________ Contact #__________________________

______________________________ Contact #__________________________

Please list all of the medications you are taking. Include over the counter medications, herbs & vitamins.

Medication Name	*Dose*	*Last taken*	*Medication Name*	*Dose*	*Last taken*

Please list and describe allergic reactions you have had to food, medications or insect stings.
Check if you are you allergic to ❑Shellfish __________ ❑IV Contrast Dye __________ ❑Penicillins __________

Please list Food, Medication or Insect Allergies	*Reaction*

Please list your occupations. Include the length of time you performed in that role, and describe your work responsibilities in that occupation. (Include military experience.)

Occupation	Start Date	Stop Date	Responsibilities

Have you ever been exposed to known cancer causing agents or inhalation hazards? ❑Yes ❑No
Examples: asbestos, paints, aniline dyes, chemicals, silica, etc.
If yes, please list types of exposure, time period exposed, and health problems experienced at time of exposure

Agent	Start Date	Stop Date	Health problems resulting from exposure

Please describe your hobbies.

______________________ ______________________

______________________ ______________________

Have you traveled, in the past 1 year? ❑Yes ❑No
If so, please describe where, when, and for how long you were there.

Travel destinations OUTSIDE the United States	Dates spent at this destination

Travel destinations INSIDE the United States	Dates spent at this destination

Do you exercise? ❑Yes ❑No If yes, describe how long and how often you exercise on average each week

____

____

In the past 12 months, have you fallen? ❑Yes ❑No If yes, how many times? _______
If yes, have you ever broken bones, or sustained an injury, as a result of falling? **❑Yes ❑No**

New Health Care Consumer Questionnaire
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Do you have a history of smoking? ❑**Yes** ❑**No** If yes, ______ # packs per day X ______ for # years
Have you ever chewed tobacco? ❑**Yes** ❑**No**
Have you ever smoked pipes or cigars? ❑**Yes** ❑**No** If yes, how many cigars or bowls _____ per ❑Day ❑Week
Have you quit? If so, when. ❑**Yes** ❑**No** ______________________________
Have you considered quitting? ❑**Yes** ❑**No** If yes, have you set a date to quit? ❑**Yes** ❑**No**
Have you tried quitting? ❑**Yes** ❑**No** If yes, what is the longest time period you quit smoking? ________

Do you have a history of alcohol use? ❑**Yes** ❑**No** If yes, specify _______ # drinks per ❑Day ❑Week
1 "drink" is equal to 12 oz. can of beer, 1.5 oz. liquor (80 proof) or 5 oz wine
Have you ever experienced a blackout, or loss of consciousness due to alcohol intake? ❑**Yes** ❑**No**
Have you ever needed to drink to prevent yourself from shaking, sweating, and becoming irritable? ❑**Yes** ❑**No**
Have you ever been arrested or ticketed for DUI (Driving Under the Influence)? ❑**Yes** ❑**No**
Have you been involved in any motor vehicle accidents in the past 12 months? ❑**Yes** ❑**No**

Do you use drugs for recreational purposes? ❑**Yes** ❑**No**
If yes, check all that apply ❑Amphetamines ❑Cocaine ❑Marijuana ❑Heroin ❑Inhalants ❑LSD

Method of delivery you chose ❑Ingestion ❑Injection ❑Inhalation

How much would you use ______________________________

How long did you use drugs ______________________________

Have you quit? ❑**Yes** ❑**No** If so, when ______________________________

Have you ever taken drugs to prevent shaking, sweating and becoming irritable? ❑**Yes** ❑**No**

Have you ever had a problem with addiction to prescription pain medication or benzodiazepines? ❑**Yes** ❑**No**
If yes, specify when and which drugs. ______________________________

Are you sexually active? ❑**Yes** ❑**No**
If so, do you practice birth control of any kind? ❑**Yes** ❑**No** If yes, check below all that apply
❑Condoms ❑Diaphragm ❑IUD (Intrauterine Device) ❑Birth Control Pills, Patches, Implants

How many sexual partners have you had in the past 1 year?
Have you ever had sex with a person who is the same gender as yourself, bisexual, or anyone who performs sexual favors in exchange for money or drugs? ❑**Yes** ❑**No**
Have you EVER been diagnosed with a sexually transmitted disease (like syphilis, gonorrhea or HIV), or were you exposed to a sexually transmitted disease during childbirth? ❑**Yes** ❑**No**
Do you have any tattoos or body piercings? ❑**Yes** ❑**No**
Have you received any transfusions of blood or blood products? ❑**Yes** ❑**No**

Describe your seatbelt use when you are driving, or a passenger in a vehicle
❑All the time ❑Most of the time ❑About half the time ❑Rarely ❑Never

Do you keep firearms in your place of residence? ❑Yes ❑No
If yes, are they kept in locked compartments, or do they have safety locks? ❑Yes ❑No

Can you perform your own hygiene, dressing, cooking and shopping needs independently? ❑Yes ❑No

Do you feel safe in your relationship? ❑Yes ❑No
Have you ever been in a relationship where you were threatened, hurt or afraid? ❑Yes ❑No

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Patient Name ________________________________ DOB ____/____/________ Date ____/____/________

Have you ever had the following exams?
If so describe when and why

Exam	Yes	No	Description
PAP Smear	❑Yes	❑No	______________________________
Prostate Biopsy	❑Yes	❑No	______________________________
Mammogram	❑Yes	❑No	______________________________
Colonoscopy	❑Yes	❑No	______________________________
EGD (Esophageal endoscopy)	❑Yes	❑No	______________________________
EKG	❑Yes	❑No	______________________________
Cardiac stress test	❑Yes	❑No	______________________________
ECHO	❑Yes	❑No	______________________________
Chest x-ray	❑Yes	❑No	______________________________
CT “CAT” scan of chest	❑Yes	❑No	______________________________
Pulmonary function test	❑Yes	❑No	______________________________
EEG	❑Yes	❑No	______________________________
Bone density test	❑Yes	❑No	______________________________

Have you had any of the following vaccinations? Check all that apply, and specify when last received.

Yes	No	Vaccination	When
❑Yes	❑No	Influenza	______________
❑Yes	❑No	Pneumonia	______________
❑Yes	❑No	Tetanus	______________
❑Yes	❑No	BCG	______________
❑Yes	❑No	Varicella	______________
❑Yes	❑No	HPV (Gardasil)	______________

If you are female, have you ever been pregnant? ❑Yes ❑No If yes, please describe

Number of pregnancies? ______ Number of live births? ______ Number of miscarriages or abortions? _____

Age of onset of menstrual cycles? _______ **Age of onset of menopause?** _______ ❑NA

Have you ever taken birth control pills, or used birth control patches or implants? ❑Yes ❑No

If yes, what did you take and for how long? ________________________

Have you ever been on hormone replacement therapy? ❑Yes ❑No

If yes, what did you take and for how long? ________________________

Did you ever have an IUD? ❑Yes ❑No If yes, was it removed? If yes, when __________

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Past Medical History Please check all that apply.

Condition	Response
Adrenal Dysfunction	❑Yes ❑No
Alzheimer	❑Yes ❑No
Amyotrophic Lateral Sclerosis	❑Yes ❑No
Anorexia or Bulimia	❑Yes ❑No
Anxiety Disorder	❑Yes ❑No
Arteriovenous Malformations (AVMs)	❑Yes ❑No
Arthritis	❑Yes ❑No
Asthma	❑Yes ❑No
Autoimmune Disease	❑Yes ❑No
Bipolar Disorder	❑Yes ❑No
Bleeding Disorder	❑Yes ❑No
Cataracts	❑Yes ❑No
Cerebrovascular Accident (Stroke)	❑Yes ❑No
Chemotherapy If yes, state when	❑Yes ❑No
Claudication	❑Yes ❑No
Clotting Disorder	❑Yes ❑No
Congenital Heart Defects	❑Yes ❑No
Coronary Artery Disease	❑Yes ❑No
COPD	❑Yes ❑No
Cystic Fibrosis	❑Yes ❑No
Depression	❑Yes ❑No
Diabetes	❑Yes ❑No
Dialysis	❑Yes ❑No
Eclampsia or Pre-eclampsia	❑Yes ❑No
Endocarditis	❑Yes ❑No
Endometriosis	❑Yes ❑No
End Stage Renal Disease	❑Yes ❑No
Erectile Dysfunction	❑Yes ❑No
Esophageal Dysfunction	❑Yes ❑No
Fibromyalgia	❑Yes ❑No
Gallstones	❑Yes ❑No
Gastritis or Gastric Ulcers	❑Yes ❑No
GERD (reflux problems)	❑Yes ❑No
Glaucoma	❑Yes ❑No
Heart or Valve Defects	❑Yes ❑No
Hemochromatosis	❑Yes ❑No
Hemorrhoids	❑Yes ❑No
Hepatitis	❑Yes ❑No
HIV or AIDS	❑Yes ❑No
Hypertension	❑Yes ❑No
Hyperthyroidism	❑Yes ❑No
Hypotension	❑Yes ❑No
Hypothyroidism	❑Yes ❑No
Inflammatory Bowel Disease	❑Yes ❑No

Condition	Response
Irregular Heart Rhythm	❑Yes ❑No
Kyphosis	❑Yes ❑No
Liver Dysfunction	❑Yes ❑No
Kidney Failure, or Dysfunction	❑Yes ❑No
Malignancy If yes, describe below	❑Yes ❑No
Mania	❑Yes ❑No
Muscular Dystrophy	❑Yes ❑No
Myocardial Infarction (Heart Attack)	❑Yes ❑No
Narcolepsy	❑Yes ❑No
Obstructive Sleep Apnea	❑Yes ❑No
Organ Transplant If yes, describe	❑Yes ❑No
Osteoporosis	❑Yes ❑No
Pancreatitis	❑Yes ❑No
Periodic Limb Movement Disorder	❑Yes ❑No
Peripheral Artery Disease	❑Yes ❑No
Personality Disorder	❑Yes ❑No
Pituitary Dysfunction	❑Yes ❑No
Polycystic Ovarian Syndrome	❑Yes ❑No
Pulmonary Artery Hypertension	❑Yes ❑No
Pulmonary fibrosis	❑Yes ❑No
Radiation Therapy If yes, explain	❑Yes ❑No
Recurrent Infections	❑Yes ❑No
Restless Leg Syndrome	❑Yes ❑No
Sarcoidosis	❑Yes ❑No
Schizophrenia	❑Yes ❑No
Scleroderma	❑Yes ❑No
Scoliosis	❑Yes ❑No
Seizure Disorder	❑Yes ❑No
Sickle Cell	❑Yes ❑No
Sjogren	❑Yes ❑No
Skin Disorders (Psoriasis, Acne)	❑Yes ❑No
Thalassemia	❑Yes ❑No
Thrombocytopenia	❑Yes ❑No
Thrombophilia	❑Yes ❑No
Transfusions	❑Yes ❑No
Tuberculosis	❑Yes ❑No
If yes, have you been treated?	❑Yes ❑No
Urinary retention or urgency	❑Yes ❑No
Vasculitis	❑Yes ❑No
Visual defects	❑Yes ❑No
Vocal cord dysfunction/paralysis	❑Yes ❑No

Patient Name ______________________________ DOB ____/____/________ Date ____/____/________

Review of Systems In the last 6 months, have you experienced any of the following symptoms? Respond to each.

Constitutional		
Weight Loss or Gain	❑Yes	❑No
Appetite changes (increased or decreased)	❑Yes	❑No
Fatigue, profound and impairs daily function	❑Yes	❑No
Fever	❑Yes	❑No
Shakes/sweats from lack of alcohol or drug	❑Yes	❑No

Eyes		
Eye pain or drainage	❑Yes	❑No
Visual changes	❑Yes	❑No
Dry, irritated eyes	❑Yes	❑No

ENT/Mouth		
Ear pain or drainage	❑Yes	❑No
Frequent sinus infections	❑Yes	❑No
Hearing changes or loss	❑Yes	❑No
Nosebleeds	❑Yes	❑No
Dizziness	❑Yes	❑No

Respiratory		
Blood in your sputum	❑Yes	❑No
Chest tightness	❑Yes	❑No
Cough lasting >1 month, productive or not	❑Yes	❑No
Shortness of breath	❑Yes	❑No
Wheezing	❑Yes	❑No
Chest pain with inhalation or coughing	❑Yes	❑No

Cardiovascular		
Chest pain or heaviness	❑Yes	❑No
Palpitations	❑Yes	❑No
Fainting or near fainting spells	❑Yes	❑No
Swelling of feet or legs	❑Yes	❑No
Shortness of breath lying flat in bed	❑Yes	❑No

Gastrointestinal		
Abdominal pain	❑Yes	❑No
Blood in your stool	❑Yes	❑No
Constipation	❑Yes	❑No
Diarrhea or Food Intolerance	❑Yes	❑No
Heartburn or Indigestion	❑Yes	❑No
Vomiting or nausea lasting for >1 day	❑Yes	❑No
Swallowing difficulty	❑Yes	❑No

Psych		
Anxiety without clear explanation	❑Yes	❑No
Sadness lasting for days or weeks	❑Yes	❑No
Hearing voices	❑Yes	❑No
Thoughts of hurting yourself	❑Yes	❑No
Thought of hurting others	❑Yes	❑No
Fear of people, places or things	❑Yes	❑No

Genitourinary		
Blood in your urine	❑Yes	❑No
Menstrual changes	❑Yes	❑No
Urinating that is painful or difficult	❑Yes	❑No
Erection problems	❑Yes	❑No
Vaginal discharge or bleeding	❑Yes	❑No

Musculoskeletal		
Broken bones	❑Yes	❑No
Joint pain or swelling	❑Yes	❑No
Muscle aches	❑Yes	❑No
Muscle weakness	❑Yes	❑No
Back pain	❑Yes	❑No

Skin/Breasts		
Masses or lumps	❑Yes	❑No
Nipple discharge	❑Yes	❑No
Rashes or nonhealing ulcers	❑Yes	❑No

Neurologic		
Seizures	❑Yes	❑No
Coughing or choking with swallowing	❑Yes	❑No
Excessive daytime sleepiness	❑Yes	❑No
Extremity pain or burning sensations	❑Yes	❑No
Hallucinations	❑Yes	❑No
Numbness or tingling	❑Yes	❑No
Difficulty falling asleep, staying asleep	❑Yes	❑No

Endocrinologic		
Hair loss	❑Yes	❑No
Frequent urination	❑Yes	❑No
Increased thirst	❑Yes	❑No
Heat or cold intolerance	❑Yes	❑No

Heme/Lymph		
Bleeding from gums or nose	❑Yes	❑No
Unexplained bruising	❑Yes	❑No
Night Sweats	❑Yes	❑No
Swollen, painful lymph nodes	❑Yes	❑No

Allergy/Immun		
Watery eyes	❑Yes	❑No
Runny nose	❑Yes	❑No
Food intolerance	❑Yes	❑No
Frequent skin sores	❑Yes	❑No

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Please list all surgical procedures you have had. Please include surgeon and date of procedure.

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Family Medical History Please list all known medical problems in your immediate family.
(Specify M=Mother, F=Father, B=Brother, S=Sister, So=Son, D=Daughter, GM=Grandmother, GF=Grandfather)

_________________ ______________________ ____________________ ___________________

_________________ ______________________ ____________________ ___________________

_________________ ______________________ ____________________ ___________________

Additional Information that you feel may be helpful for your health care provider to know.

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Health Care Provider Notes

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