

MIDWEST HEALTH CENTER, PC

Name: \_\_\_\_\_ S.S. number: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Male: \_\_\_\_\_ Female: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Name of local physician: \_\_\_\_\_ May we contact them? \_\_\_\_\_

Pharmacy: \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO US? \_\_\_\_\_

**Race:**

White Black/African American Hispanic Other: \_\_\_\_\_ I chose not to specify

**Preferred Language:**

English Spanish Sign Language Other: \_\_\_\_\_ I chose not to specify

**Ethnicity:**

Not Hispanic or Latino White Black/African American I chose not to specify

# New Patient Health Questionnaire

## Part I

Name: \_\_\_\_\_

Date: \_\_\_\_\_

DOB: \_\_\_\_\_

Age: \_\_\_\_\_

New Patient \_\_\_\_\_

Established \_\_\_\_\_

**PLEASE NOTE:**

This is a confidential record of your medical history and will be kept in this office.  
Information contained here will not be released to any person except when you have authorized us to do so.

What medical concerns bring you to our office? \_\_\_\_\_

Marital Status: (circle) S M D W Occupation: (if retired, previous occupation) \_\_\_\_\_

If disabled, check here: \_\_\_\_\_ Nature of disability \_\_\_\_\_ Birthplace: \_\_\_\_\_

Do you exercise routinely? (circle) No Yes If Yes, what exercise/how often? \_\_\_\_\_

Have you ever smoked? (circle) No Yes Cigar Pipe Cigarettes If Yes: #cigarettes/day \_\_\_\_\_ #yrs. \_\_\_\_\_

If you have never smoked, skip this question: Do you still smoke now? (circle) No Yes If No, when did you quit? \_\_\_\_\_

Have you completed Advanced Directives or do you have a Living Will? (circle) No Yes Which? \_\_\_\_\_

Caffeine: Do you drink (circle) caffeinated coffee, teas or sodas regularly? (circle) No Yes #/day \_\_\_\_\_

Tell us a little about your home environment: (e.g. live alone, with family, single parent, house, apt., etc.)

Are you under a lot of pressure at work or at home? (circle) No Yes, Which? \_\_\_\_\_

### Medical Information

**Allergies:** Are you allergic to any drugs? (circle) No Yes Please list: \_\_\_\_\_

**Medications** (list all medications you are taking regularly. Include over the counter, herbal or natural remedies.)


**Medical Illnesses or Conditions** (list any chronic conditions which you have been diagnosed to have)


**Have you ever had or been diagnosed to have:** (check box by all that apply)

Cataracts		Heart Disease		Ulcers		Anemia		Depression	
Glaucoma		Heart Murmur		Digestive Disorder		Bleeding Disorders		Frequent Infection	
Asthma		High Blood Pressure		Hemorrhoids		Bone or Joint Disease		Cancer (type)	
Allergies		Pneumonia		Kidney Disease		German Measles		High Cholesterol	
Stroke		TB/Lung Disease		Kidney Stone(s)		Rheumatic Fever		Prostate Enlargement	
Seizures/Epilepsy		Pleurisy		Diabetes or PreDiabetes		Chicken Pox			
Heart Attack or Angina		Jaundice or Liver Disease		Thyroid Disease		Syphilis			

**Operations:**

Please list any surgery and approximate year

Year	Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Hospitalizations:**

Other than operations

Year	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Medical History	Age	Health <i>(list significant illness)</i>	Age at Death	If deceased, cause	Comments
Father					
Mother					
Brothers or Sisters					
Spouse					
Children					

**Has any blood relative ever had?** *(check if Yes and indicate relationship)*

Alzheimer's \_\_\_\_\_     Heart Attack before age 55 \_\_\_\_\_     Alcoholism \_\_\_\_\_  
 Tuberculosis \_\_\_\_\_     Bleeding Disease \_\_\_\_\_     Mental Disorder \_\_\_\_\_  
 Diabetes \_\_\_\_\_     Stroke \_\_\_\_\_     Allergies \_\_\_\_\_  
 High Blood Pressure \_\_\_\_\_     Seizures \_\_\_\_\_     Asthma \_\_\_\_\_  
 Heart Disease \_\_\_\_\_     Depression/Suicide \_\_\_\_\_     Cancer \_\_\_\_\_

**Immunizations** *(check if Yes and indicate year of last injection)*

Influenza \_\_\_\_\_     Pneumonia \_\_\_\_\_     MMR \_\_\_\_\_  
 Tetanus \_\_\_\_\_     Hepatitis A or B \_\_\_\_\_     Other \_\_\_\_\_

**Transfusions:** Have you ever had a blood or plasma transfusion *(circle)* No Yes

**Weight:** What is your weight now? \_\_\_\_\_ One year ago? \_\_\_\_\_ Maximum? \_\_\_\_\_ When? \_\_\_\_\_

**Females Only:** Are you pregnant, planning a pregnancy or nursing a child? *(circle)* No Yes

Date of last menstrual period? \_\_\_\_\_

# New Patient Health Questionnaire

## Part 2

Name: \_\_\_\_\_

DOB/ID: \_\_\_\_\_

**Systems Review:** Please indicate those items that have been a recurrent or a recent significant change.

Yes	No		Yes	No	
		<b>Constitutional Symptoms</b>			<b>Genitourinary</b>
___	___	Good health lately	___	___	Frequent urination
___	___	Recent significant weight change	___	___	Burning or pain on urination
___	___	Unusual fatigue or weakness	___	___	Blood in urine
___	___	Frequent headaches	___	___	Change in force or strain when urinating
		<b>Eyes</b>	___	___	Incontinence or dribbling of urine
___	___	Change in vision	___	___	Sexual difficulties
___	___	Blurred or double vision	___	___	Men: Testicular pain
___	___	Eye disease or injury	___	___	Women: Painful periods
___	___	Wear glasses/contact lenses?	___	___	Irregular periods
		<b>Ears/Nose/Mouth/Throat/Neck</b>	___	___	Recurrent vaginal discharge
___	___	Do you wear hearing aids?	Number of pregnancies (including miscarriages): _____		
___	___	Hearing loss or ringing in ears?	___	___	# Deliveries      # Miscarriages
___	___	Earaches or drainage?	Method of birth control (if applicable) _____		
___	___	Chronic sinus problems or runny nose	Menopausal, since when: _____		
___	___	Nose bleeds	Date of last menstrual period: _____		
___	___	Mouth sores	Date of last pap smear: _____		
___	___	Bleeding gums	Date of last mammogram: _____		
___	___	Sore throat/hoarseness or voice change	<b>Yes</b>	<b>No</b>	<b>Musculoskeletal</b>
___	___	Lumps or swollen glands in neck	___	___	Joint pain(s)
___	___	Difficulty swallowing	___	___	Joint stiffness/swelling or warmth
___	___	Neck pain or stiffness	___	___	Weakness of muscles or joints
		<b>Cardiovascular</b>	___	___	Muscle pain or recurrent cramps
___	___	Heart trouble	___	___	Back pain
___	___	Chest pain or angina pectoris	___	___	Cold hands or feet
___	___	Palpitations	___	___	Difficulty in walking
___	___	Shortness of breath with walking or lying flat			<b>Integumentary (Skin/Breast)</b>
___	___	Swelling feet, ankles or hands	___	___	Rashes or itching
___	___	Waking at night with shortness of breath	___	___	Change in skin color or moles
		<b>Respiratory</b>	___	___	Change in hair or nails
___	___	Chronic or frequent cough	___	___	Varicose veins
___	___	Coughing or spitting up blood	___	___	Breast pain
___	___	Shortness of breath	___	___	Breast lump
___	___	Asthma or recurrent wheezing	___	___	Breast discharge or rash
		<b>Gastrointestinal</b>			<b>Neurological</b>
___	___	Loss of appetite	___	___	Frequent, recurring or increasing headaches
___	___	Change in bowel movements	___	___	Light-headedness or dizziness
___	___	Nausea or vomiting	___	___	Convulsions, seizures or spasms
___	___	Painful bowel movements or constipation	___	___	Numbness or tingling sensations
___	___	Frequent diarrhea	___	___	Tremors
___	___	Rectal bleeding or blood in stool	___	___	Paralysis
___	___	Stomach/abdominal pains or heartburn	___	___	Stroke
___	___	Black or tarry stools	___	___	Head injury

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please complete other side of form: *Over please*



## Physical Questionnaire - Level 2

Name \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

PLEASE NOTE: This section of the medical history contains questions that may be of a very personal and highly confidential aspect of your health. While we treat all information in your medical chart as confidential records, this section of the questionnaire is filed separately from the general medical data. It can be released only upon written consent from you for psychiatric, mental health and substance abuse records.

The following sets of questions are to help us identify problem areas that may be difficult to discuss. Circle **yes** or **no** to each question and discuss any **yes** answers with your physician or nurse practitioner.

Do you drink alcohol? (circle) *No Yes* If Yes, check the following:

\_\_\_\_ Rarely social (less than once/wk)  
\_\_\_\_ Beer, 12 oz./day  
\_\_\_\_ Wine, 1 glass/day

\_\_\_\_ Hard liquor, 1-3 oz./day  
\_\_\_\_ Beer, 2 bot./day  
\_\_\_\_ Wine, 2 glasses/day

\_\_\_\_ Hard liquor, over 3 oz./day  
\_\_\_\_ Beer, 3 bot. or more /day  
\_\_\_\_ Wine, 3 or more glasses/day

Do you use regularly or have you used in the past marijuana, cocaine, heroin, speed, crack or other inhalants? *No Yes*

Have you felt you need alcohol or other drugs (such as wine, beer, hard liquor, pot, coke, heroin, or other inhalants)?  
*No Yes*

Have you tried to cut down or quit drinking alcohol or your use of drugs?  
*No Yes*

Have you felt that you use too much alcohol or other drugs?  
*No Yes*

Do you feel you have a drinking or a drug problem at this time?  
*No Yes*

### Personal Safety

Do you feel safe at home? *No Yes*

Does he or she threaten you? *No Yes*

We all have arguments - when you and your partner or a family member argue, have you ever been physically hurt or threatened?  
*No Yes*

Has your partner (or a family member) ever hit, pushed, shoved, punched or kicked you?  
*No Yes*

Do you feel your partner or a family member controls (or tries to control) your behavior too much? *No Yes*

Have you ever felt forced to engage in unwanted sexual acts or sexual contact with your partner or other family member?  
*No Yes*

### Mental Health

Have you been diagnosed to have depression? *No Yes*

Have you been diagnosed to have bipolar disorder, obsessive compulsive disorder, or other psychiatric condition? *No Yes*

### HIV Exposure

Have you ever been diagnosed to be HIV Positive? *No Yes*

Do you have any concerns about possible exposure that you would like to discuss or be tested for? *No Yes*

Patient signature \_\_\_\_\_

Physician/ARNP signature \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_