

New Adult Patient Questionnaire

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*By providing your email address, you authorize enrollment in our patient portal (My Chart). The portal is the fastest way to securely view medication lists, immunizations, past & upcoming appointment dates, lab/test results with provider comments. You can also send/receive messages securely to/from our staff.* ***Enrollment is highly encouraged,*** *as we may need to securely message you in the case of phone contact information not being up to date or if we are unable to leave a voicemail. You will receive an invitation via text or email from My Chart to enroll.*

***In addition to listing them below, please BRING* ALL *medications, supplements and vitamins to your appointment, in their original bottles!***

**Prescription Medications** (daily meds and ones taken as needed):

|  |  |  |
| --- | --- | --- |
| Name of Medication | Dose size (usually mg) / # tabs | How Often Taken |
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**Non-Prescription Medications, Vitamins, Herbs, Supplements** (daily and ones taken as needed):

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Dose | How Often Taken | Reason Taken |
|  |  |  |  |
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**Allergies or bad reactions to medicines:** 🞏 No allergies or adverse reactions to drugs

Please list the medicines you are allergic to and reaction(s) the medication caused.

|  |  |
| --- | --- |
| Medicine | Reaction it Caused |
|  |  |
|  |  |
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Please complete both sides of each page

HSHP New adult patient Qustionnaire Updated 7/13/22

**have you been diagnosed with any of the conditions below?**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No | Details |  | Yes | No | Details |
| Alcoholism |  |  |  | Heart Disease |  |  |  |
| Allergies |  |  |  | Heart Failure |  |  |  |
| Anxiety |  |  |  | Heart Murmur |  |  |  |
| Arthritis/Joint Disorder |  |  |  | Heart Attack |  |  |  |
| Asthma |  |  |  | Osteoporosis |  |  |  |
| Cancer |  |  |  | Prostate Trouble |  |  |  |
| Cataracts |  |  |  | Liver Disease |  |  |  |
| Depression |  |  |  | Seizures |  |  |  |
| Diabetes |  |  |  | Stomach Ulcers |  |  |  |
| Diverticulosis |  |  |  | Stroke |  |  |  |
| Emphysema/COPD |  |  |  | TB Disease |  |  |  |
| GERD |  |  |  | Thyroid Trouble |  |  |  |
| High Blood Pressure |  |  |  | History of Physical Abuse |  |  |  |
| High Cholesterol |  |  |  | History of Sexual Abuse |  |  |  |
| List Other Conditions: | | | | | | | |

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| **List the names of other doctors you currently see: (Example: kidney doctor, gynecologist, etc.)** |

**PLEASE LIST ANY SURGERIES YOU HAVE HAD:**

|  |  |  |
| --- | --- | --- |
| **Type of Surgery** | **Date of Surgery** | **Description (if indicated)** |
| Adenoids out |  |  |
| Appendix out |  |  |
| Tonsils out |  |  |
| Gallbladder out |  |  |
| Heart surgery |  | Describe: |
| CABG |  | Describe: |
| Valve replacement |  | Describe: |
| Fracture surgery |  | Describe: |
| Hernia Repair |  | Which Side: |
| Spine surgery |  | Describe: |
| Uterus removed |  | Reason for hysterectomy: |
| Ovaries removed |  | □ Left □ Right □ Both |
| C-Section |  | How many: |
| Tubal ligation |  |  |
| Breast surgery |  | Describe: |
| Eye surgery |  |  |
| Other Surgeries: | Date of Surgery: | Describe: |

HSHP New adult patient Qustionnaire Updated 7/13/22

**Health Maintenance**

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| **Have you had any of the following vaccines?** | **Date(s)** | **Where did you receive the vaccine?** |
| Pneumonia-Conj. Vaccine (Prevnar 13) |  |  |
| Pneumonia-Poly. Vaccine (Pneumovax) |  |  |
| Flu Shot |  |  |
| Tetanus Shot-(TD)  If yes, did tetanus include whooping cough?  (Tdap) 🞏 Yes 🞏 No 🞏Unsure |  |  |
| Zostavax (shingles) Vaccine |  |  |
| Shingrix (shingles) Vaccine |  |  |
| COVID-19 Moderna Vaccine |  |  |
| COVID-19 Pfizer Vaccine |  |  |
| COVID-19 Johnson & Johnson Vaccine |  |  |
| **Have you had any of the following scans and or screenings?** | **Date** | **Where/Results** |
| Bone Density Test (DEXA Scan) |  |  |
| **Colon Cancer Screening** | **Date** | **Where/Results** |
| Colonoscopy |  |  |
| Cologuard |  |  |
| FOBT/FIT (stool cards to check for blood) |  |  |
| ***For patients who smoke/or formally smoked only*** | **Date** | **Where/Results** |
| Abdominal Ultrasound to check for Abdominal Aortic Aneurysm (AAA) |  |  |
| CT Scan of the lungs (Low Dose CT Scan) |  |  |
| ***For patients with diabetes only*** | **Date** | **Where/Results** |
| Dilated Eye Examination |  |  |
| Hemoglobin A1c |  |  |
| Foot Exam |  |  |

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| ***For patients 65 years old & Older***  Have you fallen in the past 30 days? 🞏 Yes 🞏 No | |
| ***Health Maintenance (for women only)***  Date of last Mammogram: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Was it normal? 🞏 Yes 🞏 No  Where was last Mammogram done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of last pap smear: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Was it normal? 🞏 Yes 🞏 No  Did your last pap smear include HPV testing? 🞏 Yes 🞏 No If yes, was HPV result 🞏 Negative or 🞏 Positive  Where was last Pap smear done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you ever had an abnormal pap? 🞏 Yes 🞏 No |
| Number of pregnancies: \_\_\_\_\_ 🞏 None - Number of live births: \_\_\_\_\_ 🞏 None  Number of miscarriages: \_\_\_\_\_ 🞏 None - Number of abortions: \_\_\_\_\_ 🞏 None  Age your periods started: \_\_\_\_\_ - Age your periods ended (if applicable):  \_\_\_\_\_\_\_\_\_\_\_\_ |

HSHP New adult patient Qustionnaire Updated 7/13/22

**SOCIAL HISTORY**

🞏 Single 🞏 Married 🞏 Legally Separated 🞏 Divorced 🞏 Widowed 🞏 Significant Other 🞏 Domestic Partner

Name of Significant Other/Spouse/Partner if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have children? 🞏 Yes 🞏 No /If so, how many? \_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol Use:** Do you drink alcohol? 🞏 Yes 🞏 Not Currently 🞏 Never

If yes, on average, how many alcoholic beverages do you drink per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tobacco Use:**

**Cigarettes:** Do you currently or have previously smoked cigarettes? 🞏 Never 🞏 Sometimes

🞏 Current every day smoker. I smoke \_\_\_\_ packs per day.

🞏 Former smoker. I quit in \_\_\_\_\_\_\_ (year) after smoking \_\_\_\_\_ ppd for \_\_\_\_\_\_\_\_\_\_ years.

**Pipe/Cigars:** Do you currently or have previously smoked a pipe or cigars? 🞏 Never 🞏 Yes

🞏 Sometimes 🞏 Not Currently

**Smokeless Tobacco:** Do you currently or have previously used chewing tobacco or snuff? 🞏 Yes 🞏 Never

🞏 Sometimes 🞏 Not Currently. I quit in \_\_\_\_\_\_\_ (year)

**E-Cigarettes/Vaping:** 🞏 Never 🞏 Current every day user 🞏 Current some days 🞏 Former user

**Substance Abuse:** Current Drug Use: 🞏 Yes 🞏 Not Currently 🞏 Never

Do you have a history of addiction? 🞏 Yes 🞏 No

**Physical Activity:** On average, how many days per week do you engage in moderate to strenuous exercise? \_\_\_\_\_\_\_\_\_

**Family History**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| I am adopted 🞏 | Mother | Father | Brother(s) | Sister(s) | Mom’s Mom | Mom’s Dad | Dad’s Mom | Dad’s Dad | Other blood relatives (list relationship to you) |
| **Alive (A) or Deceased (D)** |  |  |  |  |  |  |  |  |  |
| Alcohol/Drug Abuse |  |  |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |  |  |
| Alzheimer’s Disease |  |  |  |  |  |  |  |  |  |
| Anxiety |  |  |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  |  |  |
| Breast Cancer |  |  |  |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |  |  |  |
| Colon/Rectal Cancer |  |  |  |  |  |  |  |  |  |
| COPD |  |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |  |
| Fibromyalgia |  |  |  |  |  |  |  |  |  |
| Heart Attack |  |  |  |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |  |  |  |
| Liver disease |  |  |  |  |  |  |  |  |  |
| Obesity |  |  |  |  |  |  |  |  |  |
| Other Cancer |  |  |  |  |  |  |  |  |  |
| Thyroid Disease |  |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |  |
| Suicide |  |  |  |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |  |  |  |
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**Many situations affect our health. Please mark the appropriate answer that applies to you:**

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| Over the past 2 weeks, how often have you been bothered by any of the following problems?  Little interest or pleasure in doing things:  🞏 Not at all 🞏 Several Days 🞏 More than half days 🞏 Nearly every day  Have you been feeling down, depressed or hopeless?  🞏 Not at all 🞏 Several Days 🞏 More than half days 🞏 Nearly every day |

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| What is your living situation today?  🞏 I have a steady place to live 🞏 I have a place to live today, but I am worried about losing it in the future  🞏 I do not have a steady place to live 🞏 Decline to answer |

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| Some people have made the following statements about their food situation. Please answer whether the statements were Often, Sometimes or Never true for you and your household **in the last 12 months:**  You worried that your food would run out before you got money to buy more:  🞏 Often true 🞏 Sometimes true 🞏 Never true 🞏 Decline to answer  The food you bought just didn’t last and you didn’t have money to get more:  🞏 Often true 🞏 Sometimes true 🞏 Never true 🞏 Decline to answer |

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| In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? 🞏 Yes 🞏 No 🞏 Decline to answer |

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| Because violence and abuse happens to a lot of people and affects their health, we are asking the following questions:  How often does anyone, including family and friends, physically hurt you?  🞏 Never 🞏 Rarely 🞏 Sometimes 🞏 Fairly Often 🞏 Frequently 🞏 Decline to answer  How often does anyone, including family and friends, insult or talk down to you?  🞏 Never 🞏 Rarely 🞏 Sometimes 🞏 Fairly Often 🞏 Frequently 🞏 Decline to answer  How often does anyone, including family and friends, threaten you with harm?  🞏 Never 🞏 Rarely 🞏 Sometimes 🞏 Fairly Often 🞏 Frequently 🞏 Decline to answer  How often does anyone, including family and friends, scream or curse at you?  🞏 Never 🞏 Rarely 🞏 Sometimes 🞏 Fairly Often 🞏 Frequently 🞏 Decline to answer |

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| What is the highest grade or year of school you completed?  🞏 Never attended school or only attended kindergarten 🞏 Grades 1-8 (Elementary school)  🞏 Grades 9-11 (Some high school) 🞏 Grade 12 or GED 🞏 College 1-3 years 🞏 College 4 years or more |

|  |
| --- |
| Are you having trouble getting or keeping health insurance? 🞏 Yes 🞏 No |

|  |
| --- |
| **Advance Directives:** Have you filled out forms to indicate your desires for end of life care? 🞏 Yes 🞏 No  🞏 Living will 🞏 Durable power for health care 🞏 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| There are programs to help with needs that can affect health, but they are not reaching everyone who may need them.  Would you like to be contacted to see if there are resources that might help with any of the questions above?  🞏 Yes 🞏 No \*If yes, what phone number would you like us to use to contact you?\_\_\_\_\_\_\_\_\_\_\_ |

HSHP New adult patient Qustionnaire Updated 7/13/22