

 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 |
|  |  |
|  |  |
|  |  |

 Please complete both sides of each page

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**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 (Hypertension) |  |  |  | High Cholesterol(Hyperlipidemia) |  |  |  |
| History of abuse If yes, were you a child or adult when abuse occurred? 🞏 child 🞏 adult |  |  |  | List Other Conditions: |  |  |  |

**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: |

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Health Maintenance**

|  |  |  |
| --- | --- | --- |
| **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 |  |  |

|  |
| --- |
| ***Health Maintenance (for women only)*** |
| Date of last Mammogram: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Was it normal? 🞏 Yes 🞏 NoWhere 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: \_\_\_\_\_ 🞏 NoneNumber of miscarriages: \_\_\_\_\_ 🞏 None - Number of abortions: \_\_\_\_\_ 🞏 NoneAge your periods started: \_\_\_\_\_ - Age your periods ended (if applicable): \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ |

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**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? \_\_\_\_\_\_\_\_\_\_\_\_

**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

**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:**

Do you currently smoke or have previously smoked cigarettes, pipe or cigars? 🞏 Never 🞏 Sometimes

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

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

**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

**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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