SOUTH COUNTY FAMILY CARE - NEW PATIENT HEALTH QUESTIONNAIRE

NAME: ______________________ **DATE OF BIRTH:** ______________
PHONE: ______________________ **TODAY'S DATE:** ______________

MEDICATIONS: PLEASE LIST ALL MEDICATIONS YOU TAKE IN THE SPACE BELOW
PLEASE INCLUDE HERBAL AND OVER THE COUNTER MEDICATIONS
DRUG NAME/ DOSE (miliigrams, etc)/ HOW OFTEN (daily, twice daily,etc)

Primary care physician:

ALLERGIES TO MEDICATIONS? LIST BELOW:

Gynecologic History
Menstrual history:
Age of onset:
Cycle length:
Last menstrual period:
Contraceptive method

MEDICAL HISTORY - Circle YES or NO

DIABETES	YES / NO
ABNORMAL BLOOD SUGARS	YES / NO
WEIGHT PROBLEMS	YES / NO
HIGH CHOLESTEROL	YES / NO
HIGH THYROID	YES / NO
LOW THYROID	YES / NO
THYROID NODULE/GOITER	YES / NO
OSTEOPOROSIS	YES / NO
FRACTURES	YES / NO
HIGH BLOOD CALCIUM	YES / NO
ADRENAL INSUFFICIENCY	YES / NO
LOW TESTOSTERONE	YES / NO
IRREGULAR MENSES	YES / NO
POLYCYSTIC OVARIAN SYNDROME	YES / NO
PITUITARY DISEASE	YES / NO
GROWTH HORMONE PROBLEMS	YES / NO
HIGH BLOOD PRESSURE	YES / NO
HEART ATTACK	YES / NO
ANGINA	YES / NO
STROKE/TIA	YES / NO
KIDNEY FAILURE/DIALYSIS	YES / NO
KIDNEY STONES	YES / NO
Cancer?	YES / NO

If yes, list what kind:

OTHER MEDICAL CONDITIONS? LIST BELOW:

HOSPITALIZATIONS - LIST DATES AND REASON:

SURGERIES/PREGNANCIES - LIST BELOW:

FAMILY HISTORY
LIST CONDITIONS THAT RUN IN THE FAMILY BELOW:

	CIRCLE ONE	AGE / MEDICAL CONDITIONS
FATHER	LIVING / DECEASED / UNKNOWN	
MOTHER	LIVING / DECEASED / UNKNOWN	
BROTHERS	LIVING / DECEASED / UNKNOWN	
	LIVING / DECEASED / UNKNOWN	
	LIVING / DECEASED / UNKNOWN	
SISTERS	LIVING / DECEASED / UNKNOWN	
	LIVING / DECEASED / UNKNOWN	
	LIVING / DECEASED / UNKNOWN	
	LIVING / DECEASED / UNKNOWN	
CHILDREN	LIVING / DECEASED / UNKNOWN	
	LIVING / DECEASED / UNKNOWN	
	LIVING / DECEASED / UNKNOWN	
	LIVING / DECEASED / UNKNOWN	

SOCIAL HISTORY
DO YOU USE TOBACCO? YES / NO IF YES, HOW MANY PACKS PER DAY: ______
IF NO, HAVE YOU EVER SMOKED? YES / NO
ALCOHOL USE: NEVER / RARELY / MODERATE / EVER?
DRUGS? YES/ NO IF YES, WHAT KIND?
EXERCISE RARELY/ SOMETIMES / REGULARLY HOW OFTEN? ______
MARITAL STATUS: MARRIED / SEPARATE / DIVORCED / WIDOWED
OCCUPATION: ______

NAME: ____________________

REVIEW OF SYSTEMS

General (Constitutional)

Weight change?	yes / no
Loss of appetite	yes / no
Fever	yes / no
Night sweats	yes / no
Fatigue	yes / no
Chills	yes / no

Dermatology

Rash	yes / no
Change in color of moles	yes / no
Hives	yes / no
wounds	yes / no
skin lesions	yes / no
dry skin	yes / no

Endocrinology

farigue	yes / no
excessive thirst	yes / no
excesive urination	yes / no
weight loss	yes / no
cold intolerance	yes / no
heat intolerance	yes / no
diabetes	yes / no
dry skin	yes / no
thyroid problems	yes / no
high cholesterol	yes / no

Neurology

headache	yes / no
tingling, numbness	yes / no
seizures	yes / no
insomnia	yes / no
memory loss	yes / no
dizziness	yes / no
gait abnormality	yes / no
neuralgia	yes / no
loss of consciousness	yes / no
stroke / tia	yes / no

Ophalmology (Eye)

eye irritation	yes / no
drainage from the eyes	yes / no
blurring of vision	yes / no
loss of vision	yes / no
floaters	yes / no

Respiratory

shortness of breath	yes / no
chest pain	yes / no
cough	yes / no
wheezing	yes / no
coughing blood	yes / no

Allergy

runny nose	yes / no
scratchy throat	yes / no
itchy eyes	yes / no
ear fullness	yes / no
sinus congestion	yes / no
seasonal allergies	yes / no

Blood / Lymph

swollen glands	yes / no
fatigue	yes / no
loss of appetite	yes / no
varicose veins	yes / no
easy brusing	yes / no
anemia	yes / no

Urology

difficulty urinating	yes / no
blood in urine	yes / no
urinary urgency	yes / no
frequent urination	yes / no
urinary incontinence	yes / no
recurrent UTI	yes / no
frequent night urination	yes / no
erectile dysfunction	yes / no

Nephrology (Kidney)

"CKD"	yes / no
high blood pressure	yes / no
dialysis	yes / no
kidney stone	yes / no
kidney transplant	yes / no

Head and Neck

cough	yes / no
hearing loss	yes / no
sore throat	yes / no
ringing in the ears	yes / no
trouble swallowing	yes / no
nose bleeds	yes / no
hoarseness	yes / no

Cardiology

chest pain	yes / no
palpitations	yes / no
shortness for breath	yes / no
blood clots in legs or arms	yes / no
breathless with activity	yes / no
murmur	yes / no
high blood pressure	yes / no
leg pain with exercise	yes / no
heart attack / heart trouble	yes / no
leg swelling	yes / no
high cholesterol	yes / no

Gastrointestinal

nausea	yes / no
heartburn	yes / no
vomiting	yes / no
bloating	yes / no
difficulty swallowing	yes / no
abdominal pain	yes / no
diarrhea	yes / no
constipation	yes / no
change in bowel habits	yes / no
blood in stool	yes / no

Musculoskeletal

joint stiffness	yes / no
leg cramps	yes / no
joint pain	yes / no
joint swelling	yes / no
mucsle aches	yes / no
sciatica	yes / no
gout	yes / no
osteoporosis	yes / no

Psychology

depression	yes / no
high stress level	yes / no
sleep disturbances	yes / no
suicidal thoughts	yes / no
eating disorders	yes / no
alcohol abuse	yes / no
under psychiatric care?	yes / no

Male Reproductive

difficulty with erection	yes / no
difficulty with ejaculation	yes / no
decreased sex drive	yes / no

Female Reproductive

recurrent yeast infections	yes / no
painful intercourse	yes / no
"PMS"	yes / no
fertility trouble	yes / no
vaginal itching	yes / no
irregular periods	yes / no
breast pain	yes / no
breast discharge	yes / no
last menstrual period	________

Source of information, if other than patient: ____________________

Date: __________ ____________________

Signature of patient

Reviewed by Provider:
RC / KA / NH / BC / CL