The Christ Hospital™ Health Network

Primary Care
NEW PATIENT QUESTIONNAIRE

Patient Name _____ **Date of Birth** _____

Medical History ❑ No history of medical conditions

- ❑ Alcohol/Drug abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis/gout
- ❑ Asthma
- ❑ Bladder cancer
- ❑ Blood clots
- ❑ Blood transfusion
- ❑ BRCA 1 / 2
- ❑ Breast cancer
- ❑ Breast problems
- ❑ Cancer
- ❑ Cataract
- ❑ Cervical cancer
- ❑ Chronic rashes
- ❑ Circulation problems
- ❑ Colitis/bowel disease
- ❑ Congestive heart failure
- ❑ Depression
- ❑ Diabetes
- ❑ Emphysema/COPD
- ❑ Epilepsy/seizures
- ❑ Glaucoma
- ❑ Heart attack
- ❑ Heart disease
- ❑ Heart murmur
- ❑ Heartburn/GERD
- ❑ High blood pressure
- ❑ HIV/AIDS
- ❑ Skin cancer
- ❑ Stomach ulcer
- ❑ Stroke
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ Urinary tract infection
- ❑ Viral hepatitis

Please list any other:

_____
_____
_____
_____
_____

Medications

Please list both prescription and non-prescription medications you are currently taking:

Medication	Dose	Times/day	Medication	Dose	Times/day

Allergies

Do you have any drug or environmental allergies? ❑ No ❑ Yes If YES, please list below and describe reaction.

_____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____

Surgeries

- ❑ No Surgical History
- ❑ C-Section
- ❑ Breast biopsy
- ❑ Broken bones/fractures
- ❑ CABG/Heart Bypass
- ❑ Mastectomy
- ❑ Abdominal surgery
- ❑ Hernia repair
- ❑ Gall bladder removal
- ❑ Tonsillectomy
- ❑ Appendectomy
- ❑ Joint replacement
- ❑ Cosmetic surgery
- ❑ Colon removal
- ❑ Brain
- ❑ Hysterectomy
- ❑ Sterilization
- ❑ Other _____

_____
_____

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Family Medical History – Please list relationship of family members who have/had any of the following conditions.

- ❑ Cancer _____
- ❑ Asthma _____
- ❑ Stroke _____
- ❑ HIV/AIDS _____
- ❑ Diabetes _____
- ❑ Arthritis _____
- ❑ Seizures _____
- ❑ Migraines _____
- ❑ Heart Problems _____
- ❑ High Cholesterol _____
- ❑ Skin Problems _____
- ❑ Kidney Disease _____
- ❑ High Blood Pressure _____
- ❑ Thryoid Disease _____
- ❑ Clotting Disorder _____
- ❑ Alcoholism _____

Social History

Do you drink alcohol? ❑ No ❑ Yes If YES, how many drinks per week? _____

Do you use tobacco? ❑ No ❑ Yes ❑ Cigarettes pks/day _____ ❑ eCigarettes ❑ Cigars ❑ Pipe

Do you currently use smokeless tobacco? ❑ No ❑ Yes Have you ever used smokeless tobacco? ❑ No ❑ Yes

Do you currently use recreational drugs? ❑ No ❑ Yes ❑ I prefer to discuss with the physician

Are you sexually active? ❑ No ❑ Yes Are you using contraceptives? ❑ No ❑ Yes

Personal Health History

Childhood Illness: ❑ Measles ❑ Mumps ❑ Rubella ❑ Chickenpox ❑ Rheumatic Fever ❑ Polio

Immunizations & Dates: ❑ Tetanus _____ ❑ Pneumonia _____ ❑ Hepatitis _____ ❑ Chickenpox _____
❑ Influenza _____ ❑ MMR _____ ❑ Meningococcal _____
(Measles, Mumps, Rubella)

Tests/Screenings & Dates: ❑ Eye Exam _____ ❑ Colonoscopy _____ ❑ Mammogram _____ ❑ Dexa Scan _____

WOMEN

First day of last menstrual period _____ Irregular menstrual bleeding? ❑ Yes ❑ No

Name of your Gynecologist _____ Date of last PAP _____

Have you ever had an abnormal PAP? ❑ Yes ❑ No If yes, when? _____

Number of pregnancies _____ Deliveries _____ Miscarriages _____ Abortions _____

Date of last mammogram _____

Do you have breast lumps or nipple discharge? ❑ Yes ❑ No

If no longer menstrual, have you had bleeding after menopause? ❑ Yes ❑ No

Have you ever had a bone density test? ❑ Yes ❑ No

Cervical Cancer Risks: Sexually active before age 16? ❑ Yes ❑ No

More than 5 sexual partners? ❑ Yes ❑ No

Any sexually transmitted diseases? ❑ Yes ❑ No

MEN

Do you usually get up to urinate during the night? ❑ Yes ❑ No

Do you feel pain or burning with urination? ❑ Yes ❑ No

Any blood in your urine? ❑ Yes ❑ No

Do you feel a burning discharge from penis? ❑ Yes ❑ No

Has the force of your urination decreased? ❑ Yes ❑ No

Have you had any kidney, bladder or prostate infections in the last 12 months? ❑ Yes ❑ No

Any difficulty with erection or ejaculation? ❑ Yes ❑ No

Any problems emptying your bladder completely? ❑ Yes ❑ No

Any testicle pain or swelling? ❑ Yes ❑ No

Date of last prostate and rectal exam _____

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Mental Health

Is stress a major problem for you?	❑ Yes	❑ No	Do you feel depressed?	❑ Yes	❑ No
Have you ever attempted suicide?	❑ Yes	❑ No	Do you have trouble sleeping?	❑ Yes	❑ No
Have you ever seriously thought of hurting yourself?	❑ Yes	❑ No	Do you panic when stressed?	❑ Yes	❑ No
Do you have problems with eating or your appetite?	❑ Yes	❑ No	Do you cry frequently?	❑ Yes	❑ No
Have you ever been to a counselor?	❑ Yes	❑ No			

Symptoms – In the last 6 months, have you had any problems or concerns related to the following symptoms?

Constitutional symptoms

Fever/Chills	❑ Yes	❑ No
Fatigue	❑ Yes	❑ No
Weight loss/gain (>5 lbs.)	❑ Yes	❑ No

Eyes/Ears/Nose/Throat

Vision change	❑ Yes	❑ No
Pain: Location _____	❑ Yes	❑ No
Hearing change	❑ Yes	❑ No
Dizziness	❑ Yes	❑ No
Sinus congestion/pressure	❑ Yes	❑ No
Swelling or lumps in throat	❑ Yes	❑ No

Cardiovascular

Chest pain	❑ Yes	❑ No
Palpitations	❑ Yes	❑ No
Edema/swelling in legs	❑ Yes	❑ No

Respiratory

Shortness of breath	❑ Yes	❑ No
Coughing or Wheezing	❑ Yes	❑ No

Abdomen (GI/GU)

Abdominal pain	❑ Yes	❑ No
Constipation	❑ Yes	❑ No
Diarrhea	❑ Yes	❑ No
Blood in stool/discolored stool	❑ Yes	❑ No
Heartburn or indigestion	❑ Yes	❑ No
Difficulty swallowing	❑ Yes	❑ No
Nausea/vomiting	❑ Yes	❑ No
Change in frequency of urination	❑ Yes	❑ No
Painful urination	❑ Yes	❑ No
Blood in urine	❑ Yes	❑ No
Urinary or stool incontinence	❑ Yes	❑ No

Musculoskeletal

Back pain/neck pain	❑ Yes	❑ No
Joint pain or swelling	❑ Yes	❑ No
Muscle pain	❑ Yes	❑ No

Skin

Rash	❑ Yes	❑ No
Skin growth	❑ Yes	❑ No
New or changed moles	❑ Yes	❑ No
Persistent itch	❑ Yes	❑ No

Neurological

Headaches - frequent or severe	❑ Yes	❑ No
Change in thinking, confusion	❑ Yes	❑ No
Memory loss	❑ Yes	❑ No
Trouble speaking	❑ Yes	❑ No
Weakness	❑ Yes	❑ No
Loss of coordination, falling	❑ Yes	❑ No
Change in sensation-numbness	❑ Yes	❑ No

Psychiatric

Change in mood or anxiety	❑ Yes	❑ No
Trouble sleeping	❑ Yes	❑ No

Endocrine

Excessive/increased thirst	❑ Yes	❑ No
Heat/cold intolerance	❑ Yes	❑ No
Too hot/cold	❑ Yes	❑ No

Hematological/Lymphatic

Blood clotting problems	❑ Yes	❑ No
Easy bruising or bleeding	❑ Yes	❑ No
Enlarged lymph nodes	❑ Yes	❑ No

Physician/Provider Signature: _____ **Date:** _____