

## Well Primary Care Comprehensive New Patient Questionnaire

Welcome to Well Primary Care. Thank you for taking the time to fill out this form regarding your health history as this will help guide me in caring for you.

Name:

What are your goals in joining this practice?

What are your biggest health concerns?

How would you rate your health?    Excellent    Good    Fair    Poor

### Medications:

Please list all prescriptions and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc).

- Check box if you do not take any prescription or over the counter medications.
- Check box if you brought a list of your medications.

Medication	Dose (e.g. mg/pill)	How many times per day?

Allergies or intolerance to medication?

Medication	Reaction

**Personal Medical History:**

Condition	Now	Past	Comments

**Personal Surgical History:**

Procedure	Date	Comments

**Hospitalizations:**

Reason	Date	Comments

**Family History:**

Adopted?  No  Yes Family History unknown?  No  Yes

Relative	Age (if living)	Age/ Year of Death	Current Illness	Cause of Death
Mother				
Father				
Brother				
Sister				
Children				

**Immunizations:**

Enter year (if known) of any vaccinations you have had.

Tetanus (Td) \_\_\_\_\_ With Pertussis (Tdap) \_\_\_\_\_

Varicella (Chicken Pox) shot or illness \_\_\_\_\_

Pneumovax (pneumonia) \_\_\_\_\_ Pevnar 13 (pneumonia) \_\_\_\_\_

Influenza (flu shot) \_\_\_\_\_

MMR \_\_\_\_\_ Meningitis \_\_\_\_\_ HPV \_\_\_\_\_

Zostavax (shingles) \_\_\_\_\_ Shingrix (shingles) \_\_\_\_\_

COVID-19 Pfizer \_\_\_\_\_ Moderna \_\_\_\_\_ J&J \_\_\_\_\_

**Health Maintenance Screening Tests:**

Lipid (cholesterol) Date \_\_\_\_\_ Result \_\_\_\_\_

Sigmoidoscopy or Colonoscopy (circle one) Date (year) \_\_\_\_\_ Abnormal?  No  Yes

Polyp?  No  Yes

**Women's Health History:**

Age at beginning of periods (menstruation): \_\_\_\_\_

Age at end of periods (menopause/hysterectomy): \_\_\_\_\_  Not applicable

Do you have concerns about your periods or menopause you'd like to discuss?  No  Yes

If you are having periods, how often do they occur? Every \_\_\_\_\_ days. How long do they last? \_\_\_\_\_ days.

Total number of pregnancies: \_\_\_\_\_ Number of births: \_\_\_\_\_ Number of miscarriages: \_\_\_\_\_

Number of abortions: \_\_\_\_\_

Mammogram Most recent date/where \_\_\_\_\_ Abnormal?  No  Yes

Pap Smear Most recent date/where \_\_\_\_\_ Abnormal?  No  Yes

Bone Density Test Most recent date/where \_\_\_\_\_ Abnormal?  No  Yes

**Health Issues:**

**Tobacco Use:**

Smoke or smoked cigarettes/ pipe/ cigars (circle)?  Never  Yes

Exposure to secondhand smoke?  No  Yes

(If never used any tobacco can skip to Alcohol Use section below)

Current smoker: Packs/day: \_\_\_\_\_ # of years: \_\_\_\_\_

Former smoker: Quit date: \_\_\_\_\_

Approximately how many packs/day did you smoke? \_\_\_\_\_

How many years did you smoke? \_\_\_\_\_

Other tobacco? (circle) Snuff or Chew Currently use?  Yes

Are you ready to quit?  No  Yes

**Alcohol Use:**

Do you drink alcohol?  No  Yes

# of drinks/week: \_\_\_\_\_  Beer  Wine  Liquor

How many times in a year have you had >3 drinks (for women) >4 drinks (for men) in a day?

\_\_\_\_\_

**Drug Use:**

Have you ever used recreational drugs?  No  Yes

If yes, which ones? \_\_\_\_\_

Quit which ones?  All \_\_\_\_\_

Any used currently? \_\_\_\_\_

**Safety:**

Does your home have a working smoke detector?  No  Yes

Do you have guns in your home?  No  Yes

If yes, are they locked up & ammo stored separately?  No  Yes

Military Service?  No  Yes

History of Blood Transfusion?  No  Yes

Exposure to toxic chemicals at work?  No  Yes

Exposure to toxic chemicals doing hobbies?  No  Yes

Do you use a helmet for recreational activities? (e.g. bike, skateboard, ski)

Not applicable  Yes  No

Do you use seatbelts consistently?  No  Yes

**Sexual Activity:**

Are you sexually involved:  Not currently  Never  Yes

Sexual partner(s) is/are/have been/may be in future:  male  female

Birth control method or STD prevention (check all that apply):  None needed  Condom  Pill

IUD  Patch  Ring  Diaphragm  Vasectomy  Tubal ligation  Other method

(specify): \_\_\_\_\_

**Diet:**

Do you follow a special diet?    Vegetarian    Vegan    Gluten Free    Paleo    Other

**Exercise:**

Do you exercise regularly?  No  Yes

If yes, what kind of exercise? \_\_\_\_\_

How long (minutes)? \_\_\_\_\_ How often? \_\_\_\_\_

**Mental Health:**

In the past 2 weeks: Have you been feeling down, depressed or hopeless?  No  Yes

Do you have little interest or pleasure in doing things?  No  Yes

Have you or any family members ever been hurt, insulted, threatened or screamed at, or physically abused?  No  Yes

**Socioeconomic:**

Occupation (or prior occupation): \_\_\_\_\_

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

If you are not currently working, you are:  retired  unemployed  on a leave of absence  
 disabled  homemaker  other \_\_\_\_\_

Marital status:  single  partner  married  divorced  widowed

Spouse/partner's name: \_\_\_\_\_

Number of children: \_\_\_\_\_ Ages (if minors): \_\_\_\_\_

# of grandchildren: \_\_\_\_\_ # of great grandchildren: \_\_\_\_\_

Education:  high school or GED  trade school  college  graduate school  other

Who lives at home with you:  No one  Spouse/partner  Children

Pets (what type) \_\_\_\_\_

Other (roommates, extended family, etc) \_\_\_\_\_

Please list your interests, hobbies, group involvement, volunteer work, and/or travel outside of country in the past 6 months \_\_\_\_\_

Thank you for taking the time to fill out this form.

I look forward to working with you!