Primary Health Group
HCA Virginia Health System
An HCA affiliate

New Patient Pre-appointment questionnaire

Name: ________________________ DOB: ______________ Age: ________ Sex: ___ Male ___ Female
What name would you like to be called? ____________ Race: _________
Please check one: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed
Who do you currently live with? ___ Alone ___ Family ___ Friend ___Significant other Do you feel safe ? YES NO
Current job: ___________________ Previous job: _______________ Highest level of education? __________________
_

MEDICATIONS (Please include all prescriptions, over-the-counter, vitamins, and supplements)	
NAME/DOSE OF MEDICATION	REASON FOR TAKING MEDICATION

Which of the following conditions are currently being treated or have been treated for in the past?

___Allergies ___Asthma ___Arthritis ___Anxiety/panic ___Anemia
___Abnormal EKG ___Alcoholism ___Acid reflux ___Blood clots ___Bleeding problems
___Blood Transfusion ___Back pain ___Breast lumps ___Cancer ___Chest pain
___Colitis ___Concussion ___Cold Sores ___Constipation ___Diabetes
___Depression ___Dizziness ___Diarrhea ___Drug overdose/abuse ___Eczema
___Emphysema/COPD ___Erectile dysfunction ___Epilepsy/Seizures ___Glaucoma ___Gallbladder disease
___Genital herpes ___Gout ___Headaches ___Hearing Problem ___Hernia
___Heart attack ___Heart murmur ___Heart disease ___Hepatitis ___Herniated disk
___High blood pressure ___Hemorrhoids ___Heart failure ___High cholesterol ___HIV/AIDS
___Hodgkin's ___Insomnia ___Irritable Bowel ___Kidney disease ___Kidney stones
___Liver disease ___Leukemia ___Lung problems ___Lupus ___Meningitis
___Migraines ___Muscle disease ___OCD ___Pancreatitis ___Pneumonia
___Psoriasis ___Polio ___Sickle cell disease ___Stroke ___Skin disease
___Sinus disease ___Suicide attempt ___Thyroid disease ___Tuberculosis/Positive TB test
___Ulcer disease ___Urinary infections ___Other ____

ALLERGIES TO ANY MEDICATIONS, X-RAY DYES OR OTHER SUBSTANCES? YES NO
(If yes, please list name of medication and type of reaction)
____

SURGERIES/HOSPITALIZATIONS – Please list date and details

DATE	SURG/HOSP	REASON/DETAILS

SEVERE INJURIES
Please list dates and details of any injuries you have ever had ____
____

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FAMILY HISTORY – Please put a checkmark in all applicable box. Were you adopted? YES NO

Illness	Father	Mother	Sibling	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Heart disease/attack									
High cholesterol									
High blood pressure									
Diabetes									
Stroke									
Kidney disease									
Bleeding/Clotting prob									
Asthma									
Anemia									
Colon/Bowel problems									
Breast cancer									
Skin cancer									
Prostate cancer									
Ovarian cancer									
Other cancer									
Thyroid disease									
Drug/alcohol addiction									
Depression/Anxiety									
Suicide									
Seizures/Epilepsy									
Hep C/ HIV /TB or other infectious disease									
Other:									

OB/GYN HISTORY

Date of last period: ___________ Do you suffer from PMS? YES NO

Have you ever had an abnormal pap? YES NO If yes, date and results ____________________________________

Pregnancies: Total Number ____ Full Term _____ Miscarriages ____ Abortions ____ Premature ____ Tubal _____

Complications/Pregnancy related illness?____

SOCIAL HISTORY

Are you sexually active? YES NO If yes, are your partners? MEN WOMEN BOTH

Have you ever had a sexually transmitted disease? YES NO Diagnosis: ____

What type of birth control is used between you and your partner? ____

Do you smoke? YES NO How many per day? __________How many years?__________Are you interested in quitting? YES NO

Do you use other tobacco products? _______________________________ When? ____

Do you drink alcohol? YES NO How many per day? __________ How many per week? ____________________________

Have you ever had a problem with alcohol in the past? YES NO Explain ____

Has anyone ever expressed concerns about your alcohol use? YES NO Explain _______________________________________

Do you currently use any recreational drugs? YES NO Have you had a drug addiction in the past (Rx or illegal drug use)? YES NO

IMMUNIZATIONS

Date of last Tetanus vaccine? __________________

Date of last Flu vaccine? ______________________

Date of last Pneumonia vaccine? _______________

Date of TB screening? ____________ POS NEG

Date of chicken pox disease or shot? ________________________

Date of last Shingles vaccine? ______________________________

Date of Gardasil series? _________________________________ _

HEALTH MAINTENANCE

Date your last colonoscopy? ______________

Date of your last mammogram? ______________

Date of your last eye exam? _______________

Date of your last pap smear? _____________________________

Date of your last bone density test? _________________________

Date of last annual/wellness exam? ______________

Do you consider yourself Underweight : Normal weight Overweight Obese

What kind of exercise do you do? ____ How often? _____________________

Do you wear seat belts? YES NO Do you use sunscreen? YES NO Do you text while driving? YES NO

Do you drink coffee/soda/tea? YES NO If yes, how many cups/cans a day?__________________________ ___________________