New Health Care Consumer Questionnaire
Patient Name ______________________ DOB ___/___/______ Date ___/___/______

*In order to best serve your medical needs, we ask that you complete the following questionnaire as completely as possible. The **Health Care Consumer (HCC) - Health Care Provider (HCP)** relationship is a privileged relationship built on trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false information may seriously and adversely affect your health.*

Patient Name ______________________________________ **Gender** ❑M ❑F
Last First Middle

Date of Birth (*MM/DD/YYYY*) ______/______/__________ **Social Security Number** _____ - _____ - _______

If the person completing this form is not the patient, please write your name, your relationship to the patient, and why you are completing the form for this patient.

Name__________________**Relationship**______________**Reason**__________________

Reason For Visit ____

Patient's Personal Contact Information (Address and Phone)

______________________ Home Phone ______________________

______________________ Work Phone ______________________

Emergency Contact (Address and Phone)

______________________ Home Phone ______________________

______________________ Work Phone ______________________

Insurance Information (Insurance Company, Policy Number, Contact Number)

______________________ Contact # ______________________

Policy#______________________ Fax (if known) ______________________

Additional, or Secondary Insurance Company

______________________ Contact # ______________________

Policy#______________________ Fax (if known)______________________

Have you completed a Living Will OR designated a Durable Power of Attorney for Health Care? ❑**Yes** ❑**No**
If yes, please provide a copy for your health care provider.

Do you have any religious or cultural beliefs that may impact your health care? ❑**Yes** ❑**No**
If yes, please describe
____

Methods of learning new material that I like best are:
❑Verbal Instruction ❑Written Instruction ❑Handouts ❑Visual (Pictures, Videos, etc)

❑*You Do* ❑*You Do Not* understand English well. The language you prefer ______________

Level of education completed
❑<6th grade ❑6th – 8th grade ❑9th grade ❑12th grade ❑1-4 years college ❑>4 years college

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Names and Phone Numbers for Health Care Providers (HCPs) from whom you are currently receiving care (or have seen within the past 12 months), *AND ANY* **Health Care Providers from whom you are obtaining prescriptions.**

______________________ Contact #______________________

______________________ Contact #______________________

______________________ Contact #______________________

______________________ Contact #______________________

______________________ Contact #______________________

______________________ Contact #______________________

Please list all of the medications you are taking. Include over the counter medications, herbs & vitamins.

Medication Name	*Dose*	*Last taken*	*Medication Name*	*Dose*	*Last taken*

Please list and describe allergic reactions you have had to food, medications or insect stings.
Check if you are you allergic to ☐Shellfish __________ ☐IV Contrast Dye __________ ☐Penicillins __________

Please list Food, Medication or Insect Allergies	*Reaction*

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Please list your occupations. Include the length of time you performed in that role, and describe your work responsibilities in that occupation. (Include military experience.)

Occupation	Start Date	Stop Date	Responsibilities

Have you ever been exposed to known cancer causing agents or inhalation hazards? ❑Yes ❑No
Examples: asbestos, paints, aniline dyes, chemicals, silica, etc.
If yes, please list types of exposure, time period exposed, and health problems experienced at time of exposure

Agent	Start Date	Stop Date	Health problems resulting from exposure

Please describe your hobbies.

______________________ ______________________

______________________ ______________________

Have you traveled, in the past 1 year? ❑Yes ❑No
If so, please describe where, when, and for how long you were there.

Travel destinations OUTSIDE the United States	Dates spent at this destination

Travel destinations INSIDE the United States	Dates spent at this destination

Do you exercise? ❑Yes ❑No If yes, describe how long and how often you exercise on average each week

____

____

In the past 12 months, have you fallen? ❑Yes ❑No If yes, how many times? ______
If yes, have you ever broken bones, or sustained an injury, as a result of falling? ❑Yes ❑No

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Do you have a history of smoking? ❑Yes ❑No If yes, ______ # packs per day X ______ for # years
Have you ever chewed tobacco? ❑Yes ❑No
Have you ever smoked pipes or cigars? ❑Yes ❑No If yes, how many cigars or bowls _____ per ❑Day ❑Week
Have you quit? If so, when. ❑Yes ❑No ______________________
Have you considered quitting? ❑Yes ❑No If yes, have you set a date to quit? ❑Yes ❑No
Have you tried quitting? ❑Yes ❑No If yes, what is the longest time period you quit smoking? ________

Do you have a history of alcohol use? ❑Yes ❑No If yes, specify _______ # drinks per ❑Day ❑Week
1 "drink" is equal to 12 oz. can of beer, 1.5 oz. liquor (80 proof) or 5 oz wine
Have you ever experienced a blackout, or loss of consciousness due to alcohol intake? ❑Yes ❑No
Have you ever needed to drink to prevent yourself from shaking, sweating, and becoming irritable? ❑Yes ❑No
Have you ever been arrested or ticketed for DUI (Driving Under the Influence)? ❑Yes ❑No
Have you been involved in any motor vehicle accidents in the past 12 months? ❑Yes ❑No

Do you use drugs for recreational purposes? ❑Yes ❑No
If yes, check all that apply ❑Amphetamines ❑Cocaine ❑Marijuana ❑Heroin ❑Inhalants ❑LSD

Method of delivery you chose ❑Ingestion ❑Injection ❑Inhalation

How much would you use ______________________

How long did you use drugs ______________________

Have you quit? ❑Yes ❑No If so, when ______________________

Have you ever taken drugs to prevent shaking, sweating and becoming irritable? ❑Yes ❑No

Have you ever had a problem with addiction to prescription pain medication or benzodiazepines? ❑Yes ❑No
If yes, specify when and which drugs. ______________________

Are you sexually active? ❑Yes ❑No
If so, do you practice birth control of any kind? ❑Yes ❑No If yes, check below all that apply
❑Condoms ❑Diaphragm ❑IUD (Intrauterine Device) ❑Birth Control Pills, Patches, Implants

How many sexual partners have you had in the past 1 year?
Have you ever had sex with a person who is the same gender as yourself, bisexual, or anyone who performs sexual favors in exchange for money or drugs? ❑Yes ❑No
Have you EVER been diagnosed with a sexually transmitted disease (like syphilis, gonorrhea or HIV), or were you exposed to a sexually transmitted disease during childbirth? ❑Yes ❑No
Do you have any tattoos or body piercings? ❑Yes ❑No
Have you received any transfusions of blood or blood products? ❑Yes ❑No

Describe your seatbelt use when you are driving, or a passenger in a vehicle
❑All the time ❑Most of the time ❑About half the time ❑Rarely ❑Never

Do you keep firearms in your place of residence? ❑Yes ❑No
If yes, are they kept in locked compartments, or do they have safety locks? ❑Yes ❑No

Can you perform your own hygiene, dressing, cooking and shopping needs independently? ❑Yes ❑No

Do you feel safe in your relationship? ❑Yes ❑No
Have you ever been in a relationship where you were threatened, hurt or afraid? ❑Yes ❑No

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Have you ever had the following exams?
If so describe when and why

PAP Smear ❑Yes ❑No ____________________

Prostate Biopsy ❑Yes ❑No ____________________

Mammogram ❑Yes ❑No ____________________

Colonoscopy ❑Yes ❑No ____________________

EGD (Esophageal endoscopy) ❑Yes ❑No ____________________

EKG ❑Yes ❑No ____________________

Cardiac stress test ❑Yes ❑No ____________________

ECHO ❑Yes ❑No ____________________

Chest x-ray ❑Yes ❑No ____________________

CT "CAT" scan of chest ❑Yes ❑No ____________________

Pulmonary function test ❑Yes ❑No ____________________

EEG ❑Yes ❑No ____________________

Bone density test ❑Yes ❑No ____________________

Have you had any of the following vaccinations? Check all that apply, and specify when last received.

❑Yes ❑No Influenza ____________
❑Yes ❑No Pneumonia ____________
❑Yes ❑No Tetanus ____________
❑Yes ❑No BCG ____________
❑Yes ❑No Varicella ____________
❑Yes ❑No HPV (Gardasil) ____________

If you are female, have you ever been pregnant? ❑Yes ❑No If yes, please describe

Number of pregnancies? _____ Number of live births? _____ Number of miscarriages or abortions? _____

Age of onset of menstrual cycles? _____ **Age of onset of menopause?** _____ ❑NA

Have you ever taken birth control pills, or used birth control patches or implants? ❑Yes ❑No

If yes, what did you take and for how long? ____________________

Have you ever been on hormone replacement therapy? ❑Yes ❑No

If yes, what did you take and for how long? ____________________

Did you ever have an IUD? ❑Yes ❑No If yes, was it removed? If yes, when ________

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Past Medical History Please check all that apply.

Adrenal Dysfunction
Alzheimer
Amyotrophic Lateral Sclerosis
Anorexia or Bulimia
Anxiety Disorder
Arteriovenous Malformations (AVMs)
Arthritis
Asthma
Autoimmune Disease
Bipolar Disorder
Bleeding Disorder
Cataracts
Cerebrovascular Accident (Stroke)
Chemotherapy If yes, state when

Claudication
Clotting Disorder
Congenital Heart Defects
Coronary Artery Disease
COPD
Cystic Fibrosis
Depression
Diabetes
Dialysis
Eclampsia or Pre-eclampsia
Endocarditis
Endometriosis
End Stage Renal Disease
Erectile Dysfunction
Esophageal Dysfunction
Fibromyalgia
Gallstones
Gastritis or Gastric Ulcers
GERD (reflux problems)
Glaucoma
Heart or Valve Defects
Hemochromatosis
Hemorrhoids
Hepatitis
HIV or AIDS
Hypertension
Hyperthyroidism
Hypotension
Hypothyroidism
Inflammatory Bowel Disease

Irregular Heart Rhythm
Kyphosis
Liver Dysfunction
Kidney Failure, or Dysfunction
Malignancy If yes, describe below

Mania
Muscular Dystrophy
Myocardial Infarction (Heart Attack)
Narcolepsy
Obstructive Sleep Apnea
Organ Transplant If yes, describe

Osteoporosis
Pancreatitis
Periodic Limb Movement Disorder
Peripheral Artery Disease
Personality Disorder
Pituitary Dysfunction
Polycystic Ovarian Syndrome
Pulmonary Artery Hypertension
Pulmonary fibrosis
Radiation Therapy If yes, explain

Recurrent Infections
Restless Leg Syndrome
Sarcoidosis
Schizophrenia
Scleroderma
Scoliosis
Seizure Disorder
Sickle Cell
Sjogren
Skin Disorders (Psoriasis, Acne)
Thalassemia
Thrombocytopenia
Thrombophilia
Transfusions
Tuberculosis
If yes, have you been treated?
Urinary retention or urgency
Vasculitis
Visual defects
Vocal cord dysfunction/paralysis

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New Health Care Consumer Questionnaire

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Review of Systems In the last 6 months, have you experienced any of the following symptoms? Respond to each.

Constitutional
Weight Loss or Gain
Appetite changes (increased or decreased)
Fatigue, profound and impairs daily function
Fever
Shakes/sweats from lack of alcohol or drug

Eyes
Eye pain or drainage
Visual changes
Dry, irritated eyes

ENT/Mouth
Ear pain or drainage
Frequent sinus infections
Hearing changes or loss
Nosebleeds
Dizziness

Respiratory
Blood in your sputum
Chest tightness
Cough lasting >1 month, productive or not
Shortness of breath
Wheezing
Chest pain with inhalation or coughing

Cardiovascular
Chest pain or heaviness
Palpitations
Fainting or near fainting spells
Swelling of feet or legs
Shortness of breath lying flat in bed

Gastrointestinal
Abdominal pain
Blood in your stool
Constipation
Diarrhea or Food Intolerance
Heartburn or Indigestion
Vomiting or nausea lasting for >1 day
Swallowing difficulty

Psych
Anxiety without clear explanation
Sadness lasting for days or weeks
Hearing voices
Thoughts of hurting yourself
Thought of hurting others
Fear of people, places or things

Genitourinary
Blood in your urine
Menstrual changes
Urinating that is painful or difficult
Erection problems
Vaginal discharge or bleeding

Musculoskeletal
Broken bones
Joint pain or swelling
Muscle aches
Muscle weakness
Back pain

Skin/Breasts
Masses or lumps
Nipple discharge
Rashes or nonhealing ulcers

Neurologic
Seizures
Coughing or choking with swallowing
Excessive daytime sleepiness
Extremity pain or burning sensations
Hallucinations
Numbness or tingling
Difficulty falling asleep, staying asleep

Endocrinologic
Hair loss
Frequent urination
Increased thirst
Heat or cold intolerance

Heme/Lymph
Bleeding from gums or nose
Unexplained bruising
Night Sweats
Swollen, painful lymph nodes

Allergy/Immun
Watery eyes
Runny nose
Food intolerance
Frequent skin sores

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Please list all surgical procedures you have had. Please include surgeon and date of procedure.

Family Medical History Please list all known medical problems in your immediate family.
(Specify M=Mother, F=Father, B=Brother, S=Sister, So=Son, D=Daughter, GM=Grandmother, GF=Grandfather)

Additional Information that you feel may be helpful for your health care provider to know.

Health Care Provider Notes