Jemez Health & Human Services

New Patient Health Questionnaire

Part 1

Name: _____ Date: _____

DOB: _____ Age: _____ New Patient ☐ Established ☐

Birthplace: _____

PLEASE NOTE: This information is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

What medical concerns bring you to our clinic? _____

Marital Status S ☐ M ☐ D ☐ W ☐ Occupation: _____

If disabled, check here: ☐ Nature of Disability _____

Do you exercise routinely? Yes ☐ No ☐ If yes, what exercise & how often? _____

Have you every smoked? Yes ☐ No ☐ Cigar/ Pipe ☐ Cigarettes ☐ If, yes #/day _____ # of years _____

If you have never smoked, skip this question: Do you still smoke now? Yes ☐ No ☐ If no, when did you quit? _____

Have you completed Advanced Directives or do you have a Living Will? _____

Caffeine: Do you drink caffeinated coffee, teas, or sodas regularly? Yes ☐ No ☐ What Kind? #/day _____

Tell us a little about your home environment: *(live alone, with family, single parent, house, apartment...)*

_____

Are you under a lot of pressure at work, home or school? Yes ☐ No ☐ _____ *Which source?*

Medical Information

Allergies: Are you allergic to any drugs? Yes ☐ No ☐ Please list: _____

Medications: *(List all medications you are taking regularly, including over the counter, herbal or natural remedies)*

_____ _____

_____ _____

_____ _____

_____ _____

Medical Illnesses or Conditions: *(list any chronic conditions, which you have been diagnosed with)*

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever had or been diagnosed with: (check all boxes that apply to you)

Cataracts		Heart Disease		Ulcers		Anemia		Depression	
Glaucoma		Heart murmur		Digestive Disorder		Bleeding Disorders		Frequent Infection	
Asthma		High Blood pressure		Hemorrhoids		Bone or Joint Disease		Cancer (type)	
Allergies		Pneumonia		Kidney Disease		German Measles		High Cholesterol	
Stroke		TB/Lung Disease		Kidney Stone(s)		Rheumatic Fever		Prostate Enlargement	
Seizure/Epilepsy		Pleurisy		Diabetes or Prediabetes		Chicken Pox			
Heart Attack or Angina		Jaundice or Liver Disease		Thyroid Disease		Syphilis			

New Patient Health Questionnaire

Name: _____ DOB/ID: _____

Operations:

Please list any surgery and approximate year

Year	Surgery

Hospitalizations:

Other than operations:

Year	Reason	Hospital

Family Medical History	Age	Health List illnesses	If Deceased, Cause	Age at Death	Comments
Father					
Mother					
Brother					
Sister					
Spouse					
Children					

Has any blood relative ever had? (check if yes & indicate relationship)

☐	Alzheimer's	_____	☐	Heart Attack (before 55)	_____	☐	Alcoholism	_____
☐	Tuberculosis	_____	☐	Bleeding Disease	_____	☐	Mental Disorder	_____
☐	Diabetes	_____	☐	Stroke	_____	☐	Allergies	_____
☐	High Blood Pressure	_____	☐	Seizures	_____	☐	Asthma	_____
☐	Heart Disease	_____	☐	Depression/Suicide	_____	☐	Cancer	_____

Immunizations: (check if yes & indicate year of last shot)

☐	Influenza	_____	☐	Pneumonia	_____	☐	MMR	_____
☐	Tetanus	_____	☐	Hepatitis A or B	_____	☐	Other	_____

Transfusions: Have you ever had a blood or plasma transfusion? Yes ☐ No ☐

Weight:

What is your current weight? _____ Last Year? _____ Maximum? _____ When? _____

FEMALES ONLY:

Are you pregnant? Yes ☐ No ☐

Planning a pregnancy? Yes ☐ No ☐

Nursing? Yes ☐ No ☐

Date of last menstrual period? _____

New Patient Health Questionnaire

Part 2

Name: _____ DOB/ID: _____

Constitutional Symptoms	Yes	No
Good Health Lately	☐	☐
Recent significant weight change	☐	☐
Unusual fatigue or weakness	☐	☐
Frequent headaches	☐	☐
Eyes		
Change in vision	☐	☐
Blurred or double vision	☐	☐
Eye disease or injury	☐	☐
Wear glasses/ contact lenses	☐	☐
Ears/Nose/Mouth/Throat/Neck		
Do you wear hearing aids	☐	☐
Hearing loss or ringing in ears	☐	☐
Earaches or drainage	☐	☐
Chronic sinus problems or runny rose	☐	☐
Nose bleeds	☐	☐
Mouth sores	☐	☐
Bleeding gums	☐	☐
Sore throat/hoarsness or voice change	☐	☐
Lumps or swollen glands in neck	☐	☐
Difficulty swallowing	☐	☐
Neck pain or stiffness	☐	☐

Cardiovascular	Yes	No
Heart trouble	☐	☐
Chest pain or angina pectoris	☐	☐
Palpitations	☐	☐
Shortness of breath with walking or lying flat	☐	☐
Swelling feet, ankles or hands	☐	☐
Waking at night with shortness of breath	☐	☐
Respiratory		
Chronic or frequent cough	☐	☐
Coughing or spitting up blood	☐	☐
Shortness of breath	☐	☐
Asthma or recurrent wheezing	☐	☐
Gastrointestinol		
Loss of appetite	☐	☐
Change in bowel movements	☐	☐
Nausea or vomiting	☐	☐
Painful bowel movements or constipation	☐	☐
Frequent diarrhea	☐	☐
Rectal bleeding or blood in stool	☐	☐
Stomach/abdominal pains or heartburn	☐	☐
Black or tarry stools	☐	☐

Comments: _____

_____

Genitourinary		Yes	No
Frequent urination		☐	☐
Burning or pain on urination		☐	☐
Bloood in urine		☐	☐
Change in force or strain when urinating		☐	☐
Incontinence or dribbling of urine		☐	☐
Sexual difficulties		☐	☐
Men:	Testicular pain	☐	☐
Women:	Painful periods	☐	☐
	Irregular periods	☐	☐
Recurrent vaginal discharge		☐	☐

Number of pregnancies (including miscarriages) _____

_____ # Deliveries _____ # Miscarriages

Method of birth control (if applicable) _____

Menopausal, since when: _____

Date of last pap smear: _____

Date of last mammogram: _____

Musculoskeletal	Yes	No
Joint pain(s)	☐	☐
Joint stiffness/swelling or warmth	☐	☐
Weakness of muscles or joints	☐	☐
Muscle pain or recurrent cramps	☐	☐
Back pain	☐	☐
Cold hands and feet	☐	☐
Difficulty in walking	☐	☐
Integumentary (Skin/Breast)		
Rashes or itching	☐	☐
Change in skin color or moles	☐	☐
Change in hair or nails	☐	☐
Varicose veins	☐	☐
Breast pain	☐	☐
Breast lump	☐	☐
Breast discharge or rash	☐	☐
Neurological		
Frequent, recurring or increasing headaches	☐	☐
Light-headedness or dizziness	☐	☐
Convulsions, seizures or spasms	☐	☐
Numbness or tingling sensations	☐	☐
Tremors	☐	☐
Paralysis	☐	☐
Stroke	☐	☐
Head injury	☐	☐

Please continue to other side of form

New Patient Health Questionnaire

Name: _____ DOB/ID: _____

Psychiatric	Yes	No
Memory loss or confusion	☐	☐
Nervousness	☐	☐
Insomina	☐	☐
Depression	☐	☐

Endocrine	Yes	No
Glandular or hormone problem	☐	☐
Heat or cold intolerence	☐	☐
Excessive thirst or urination	☐	☐
Change in hand or glove size	☐	☐

Hematologic/Lymphatic	Yes	No
Slow to heal after cuts or wounds	☐	☐
Bleeding or bruisng tendency	☐	☐
Recurrent anemia	☐	☐
Swelling, warmth or tenderness of veins or history of phlebitis	☐	☐

Allergic/Immunologic	Yes	No
History of skin reaction or other adverse reaction to: _____	☐	☐
Penicillian or other antibiotic: describe reaction: _____	☐	☐
Morphine, Demerol or other narcotics reaction: _____	☐	☐
Novocain or other narcotics reaction: _____	☐	☐
Novocain or other anesthetics reaction: _____	☐	☐
Aspirin or other pain remedies reaction: _____	☐	☐
Tetanus antitoxin or other serums	☐	☐
Iodine, methiolate or other antiseptic	☐	☐
Other medications: _____	☐	☐
Other know food allergies: _____ _____	☐	☐

Comments: _____

_____

_____

_____

Patient signature: _____ Reviewed by: _____

Date: _____ Date: _____

Hx: _____

_____

_____

_____

_____

_____

_____

_____

_____

Physician Signature: _____ Date: _____