

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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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 _____

New Health Care Consumer Questionnaire

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Past Medical History Please check all that apply.

Adrenal Dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heart Rhythm	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kyphosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Amyotrophic Lateral Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia or Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Failure, or Dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Malignancy If yes, describe below	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arteriovenous Malformations (AVMs)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mania	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Myocardial Infarction (Heart Attack)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bipolar Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Narcolepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obstructive Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Organ Transplant If yes, describe	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cerebrovascular Accident (Stroke)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chemotherapy If yes, state when	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Pancreatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Claudication	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodic Limb Movement Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clotting Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Peripheral Artery Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Defects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Personality Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary Artery Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pituitary Dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No
COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polycystic Ovarian Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cystic Fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary Artery Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy If yes, explain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Eclampsia or Pre-eclampsia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recurrent Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endocarditis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Restless Leg Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endometriosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sarcoidosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
End Stage Renal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Erectile Dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scleroderma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Esophageal Dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scoliosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gallstones	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastritis or Gastric Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sjogren	<input type="checkbox"/> Yes <input type="checkbox"/> No
GERD (reflux problems)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Disorders (Psoriasis, Acne)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thalassemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart or Valve Defects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thrombocytopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemochromatosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thrombophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemorrhoids	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV or AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, have you been treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary retention or urgency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hyperthyroidism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vasculitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypotension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Visual defects	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypothyroidism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vocal cord dysfunction/paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inflammatory Bowel Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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

Constitutional

- Weight Loss or Gain Yes No
- Appetite changes (increased or decreased) Yes No
- Fatigue, profound and impairs daily function Yes No
- Fever Yes No
- Shakes/sweats from lack of alcohol or drug Yes No

Eyes

- Eye pain or drainage Yes No
- Visual changes Yes No
- Dry, irritated eyes Yes No

ENT/Mouth

- Ear pain or drainage Yes No
- Frequent sinus infections Yes No
- Hearing changes or loss Yes No
- Nosebleeds Yes No
- Dizziness Yes No

Respiratory

- Blood in your sputum Yes No
- Chest tightness Yes No
- Cough lasting >1 month, productive or not Yes No
- Shortness of breath Yes No
- Wheezing Yes No
- Chest pain with inhalation or coughing Yes No

Cardiovascular

- Chest pain or heaviness Yes No
- Palpitations Yes No
- Fainting or near fainting spells Yes No
- Swelling of feet or legs Yes No
- Shortness of breath lying flat in bed Yes No

Gastrointestinal

- Abdominal pain Yes No
- Blood in your stool Yes No
- Constipation Yes No
- Diarrhea or Food Intolerance Yes No
- Heartburn or Indigestion Yes No
- Vomiting or nausea lasting for >1 day Yes No
- Swallowing difficulty Yes No

Psych

- Anxiety without clear explanation Yes No
- Sadness lasting for days or weeks Yes No
- Hearing voices Yes No
- Thoughts of hurting yourself Yes No
- Thought of hurting others Yes No
- Fear of people, places or things Yes No

Genitourinary

- Blood in your urine Yes No
- Menstrual changes Yes No
- Urinating that is painful or difficult Yes No
- Erection problems Yes No
- Vaginal discharge or bleeding Yes No

Musculoskeletal

- Broken bones Yes No
- Joint pain or swelling Yes No
- Muscle aches Yes No
- Muscle weakness Yes No
- Back pain Yes No

Skin/Breasts

- Masses or lumps Yes No
- Nipple discharge Yes No
- Rashes or nonhealing ulcers Yes No

Neurologic

- Seizures Yes No
- Coughing or choking with swallowing Yes No
- Excessive daytime sleepiness Yes No
- Extremity pain or burning sensations Yes No
- Hallucinations Yes No
- Numbness or tingling Yes No
- Difficulty falling asleep, staying asleep Yes No

Endocrinologic

- Hair loss Yes No
- Frequent urination Yes No
- Increased thirst Yes No
- Heat or cold intolerance Yes No

Heme/Lymph

- Bleeding from gums or nose Yes No
- Unexplained bruising Yes No
- Night Sweats Yes No
- Swollen, painful lymph nodes Yes No

Allergy/Immun

- Watery eyes Yes No
- Runny nose Yes No
- Food intolerance Yes No
- Frequent skin sores Yes No

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Patient Name _____ DOB ____/____/____ Date ____/____/____

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
