East Cary Family Physicians

New Patient Health Questionnaire

PATIENT NAME:	**Date of birth:**

Medical Conditions

Have you been diagnosed with any of the following medical conditions?

- ☐ Diabetes
- ☐ Thyroid Condition
- ☐ Cancer
- ☐ Allergies
- ☐ HIV
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Asthma
- ☐ Psychiatric Conditions
- ☐ High Cholesterol

Check the box and give the date if you had any of the following:

☐ Flu shot _____ ☐ Pneumonia Shot _____ ☐ Tetanus _____

☐ Colonoscopy_____ ☐ Bone Density_____ ☐ Last physical_____

If you are a female: ☐ Last Pap Smear_____ ☐ Mammogram_____

Please list any other past medical conditions:		

List all medications that you take including prescribed drugs, inhalers, over-the-counter medications, herbal medications, etc.		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

PATIENT NAME:	**Date of birth:**

List all surgeries you have ever had.	
Year	Reason

FAMILY HEALTH HISTORY		
	AGE	SIGNIFICANT HEALTH PROBLEMS
Father		
Mother		
Brother(s)		
Sister(s)		
Other		

SOCIAL HISTORY
Have you ever smoked?
Do you drink alcohol?
Have you ever used illegal drugs?
What is your marital status?
What is your occupation?

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree.

- ☐ Unexplained changes in weight
- ☐ Coughing
- ☐ Getting up at night to urinate frequently
- ☐ Moles that concern you
- ☐ Poor memory or memory loss
- ☐ Excessive urination
- ☐ Fatigue
- ☐ Shortness of breath
- ☐ Loss of bladder control or leaking urine
- ☐ Swelling or lumps in the breast
- ☐ Depression
- ☐ Intolerance of cold
- ☐ Chest Pain
- ☐ Blood in stool or dark black stool
- ☐ Recent joint or muscle pain
- ☐ Passing out or loss of consciousness
- ☐ Excessive thirst
- ☐ Intolerance of heat