Thornville Family Medical Center
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New Patient Health Questionnaire

Name:_____ **Date of Birth:**_____**Age:**_____
Email Address:_____**Weight:**_____ **Height:**_____
Drug Allergies:_____

Chief Complaints/Health Concerns(In order of importance)

_____
_____
_____
_____
_____
_____

Hospitalizations/overnight stays, including normal pregnancies and OP Surgeries:

Year:_____ Illness/Operation_____
Year:_____ Illness/Operation_____
Year:_____ Illness/Operation_____
Year:_____ Illness/Operation_____
Year:_____ Illness/Operation_____

Past Medical History: (Please check mark the box for Yes or leave it blank for No)

- ☐ Aids or HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Trouble
- ☐ Bladder Infection
- ☐ Bleeding Tendency
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chickenpox
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease

- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ High/Low Blood Pressure
- ☐ Hive/Eczema
- ☐ Infectious Mono
- ☐ Kidney Disease
- ☐ Measles
- ☐ Migraines
- ☐ Mitral Valve
- ☐ Mumps
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Smallpox
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Transfusions
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Any other disease: Please List_____

Family History:

Has any blood relative had any of the following(if Yes check the box or leave blank if uncertain please)

Relationship:

- ☐ Allergies _____
- ☐ Anemia _____
- ☐ Bleeding Tendency _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Epilepsy _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Stoke _____
- ☐ Tuberculosis _____

Social History:

Tobacco Packs per day:____for_____years.
Alcohol drinks per week:_____
Caffeine cups per day:_____
Use of illegal drugs, if yes what type:_____

Women Only-Year of last:

Breast Exam:_____ Results:_____
Mammogram:_____ Results:_____
Pap Exam :_____ Results:_____

Age of onset of menstrual period:_____ Date of last menstrual period:_____
Use of birth control: Yes or No If yes, what type:_____

# of pregnancies:_____#of live births:_____# of miscarriages:_____# of abortions:_____

The last time you had a (year):

- ☐ Flu Vaccine
- ☐ Hepatitis Vaccine
- ☐ Pneumonia Vaccine
- ☐ Stool blood test
- ☐ Sigmoid exam
- ☐ Cholesterol test
- ☐ Tetanus shot
- ☐ TB test
- ☐ Rubella Vaccine
- ☐ Rectal exam
- ☐ Eye exam
- ☐ PSA

Medications/dosage and instructions:(Please bring medications with you for the first new patient appointment)

_____
_____
_____
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