Limestone Primary Care
Patient Centered Medical Home

New Patient Health Questionnaire

This is a confidential record of your medical history and will be kept in the office. Information contained here will not be released to any person unless you have authorized us to do so.

Name: _____ Date: _____

DOB: _____ Age: _____

General Information

Who completed this health form? _____

What is your preferred language for health care information? _____

What is the best way for the office to contact you? _____

Are you disabled? Yes ☐ No ☐

If yes, what is the nature of your disability? _____

Do you have a living will or an advance directive? Yes ☐ No ☐

If yes, what type? _____

Medical History

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

- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bleeding disorder
- ☐ Cancer: What kind: _____
- ☐ Cataracts
- ☐ Chickenpox
- ☐ Colon polyps
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes/prediabetes
- ☐ Glaucoma
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irritable bowel syndrome
- ☐ Jaundice/liver disease
- ☐ Kidney disease
- ☐ Migraines/headache
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Prostate problems
- ☐ Rheumatic fever
- ☐ Seizures/epilepsy
- ☐ STD
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid disease
- ☐ Ulcers
- ☐ Urinary incontinence
- ☐ Other:

OB/GYN History (females only):

Age of menses: Age of menopause: Method of birth control:

How many pregnancies: How many children:

Hospitalizations and Surgeries

List any hospitalizations, surgeries, or procedures you have had performed.

What	Date	What	Date

Specialists

List any other doctors involved in your care.

Name	Specialty

Health Maintenance

If you've had a test or vaccine done, list when last performed:

- ☐ Bone density test: _____
- ☐ Cholesterol screen: _____
- ☐ Colonoscopy: _____
- ☐ Dental exam: _____
- ☐ Eye exam: _____
- ☐ Flu Vaccine: _____
- ☐ Hep B vaccine: _____
- ☐ HIV testing: _____
- ☐ HPV vaccine: _____
- ☐ Mammogram: _____
- ☐ Meningococcal vaccine: _____
- ☐ Pap smear: _____
- ☐ Pneumonia vaccine: _____
- ☐ Shingles vaccine: _____
- ☐ Tetanus vaccine: _____

Family History

Please indicate if your blood relative(s) have had or currently have the following by placing an X in appropriate column:

Family Member	Alcoholism or Drug Problems	Mental Health Issues	Heart Attack/Disease	High cholesterol	High blood pressure	Diabetes	Thyroid disease	Allergies	Osteoporosis	Alzheimer's Disease	Seizure	Cancer	Other
Mother (age ___)													
Father (age___)													
Brother(s)(age___)													
Sister(s) (age___)													
Grandparents													
Biological children													
Other:													

Social History

Do you drink alcohol? ☐ Yes ☐ No
If you answered yes, answer these additional questions:

- What type of alcohol? _____
- How frequently? _____
- Have you ever felt you should cut down on your drinking or drug use?
  ☐ Yes ☐ No
- Have people annoyed you by criticizing your drinking or drug use?
  ☐ Yes ☐ No
- Have you ever felt bad or guilty about your drinking or drug use?
  ☐ Yes ☐ No
- Have you ever felt the need for an "eye-opener" or awakened wanting a drink or another drug?
  ☐ Yes ☐ No

Have you ever had a substance abuse problem? ☐ Yes ☐ No
If you answered yes, answer these additional questions:

- What type of drugs do (or did) you use? _____
- How frequently? _____

Have you ever smoked? ☐ Yes ☐ No
If you answered yes, answer these additional questions:

- Do you still smoke? ☐ Yes ☐ No
- How many cigarettes/day? _____
- How many years have you smoked? _____
- If you recently stopped smoking, when did you quit? _____

Occupation: _____ ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled

If retired/disabled, what was your former occupation? _____

Highest level of education completed: _____

Marital status: ☐ Single ☐ Married ☐ Dating ☐ Divorced ☐ Widowed
Number of children: _____ **Number of persons in household:** _____

Spiritual orientation: _____

Do you exercise regularly? ☐ Yes ☐ No How often? _____
What type of exercise (e.g. biking, walking, running, swimming, etc.)? _____

Over the last two weeks, how often have you been bothered by the following?

	Not at all	*Several Days*	*More than half the days*	*Everyday*
Feeling "down", depressed", hopeless	☐	☐	☐	☐
Little or no interest in doing things	☐	☐	☐	☐

Do you feel you have an adequate social life? ☐ Yes ☐ No

Do you feel you have the resources necessary to meet your daily needs? ☐ Yes ☐ No

Do you eat a healthy diet? ☐ Yes ☐ No

Do you use caffeine on a regular basis? ☐ Yes ☐ No

Do you have any sleeping problems? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No
Self-described orientation: _____

Use of contraception: ☐ Condoms ☐ Birth control ☐ Other: _____

System Review

If you experienced any of these issues in the last 10 days, place a check mark next to the symptom.

General

- ☐ Recent fever
- ☐ Excessive fatigue
- ☐ Unexplained weight gain
- ☐ Unexplained weight loss

Eyes

- ☐ Discharge
- ☐ Pain or burning
- ☐ Blurred vision
- ☐ Loss of sight
- ☐ Itching or watering

Breast

- ☐ Pain
- ☐ Lumps
- ☐ Nipple discharge

Respiratory

- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Snoring

Reproductive-Women

- ☐ Irregular periods
- ☐ Spotting between periods
- ☐ Vaginal discharge/burning
- ☐ Unusually painful periods
- ☐ Pain during intercourse

Reproductive-Men

- ☐ Discharge from penis
- ☐ Pain or swelling of testicles
- ☐ Pain during intercourse
- ☐ Problems with erection

Mental Health

- ☐ Thoughts of suicide
- ☐ Marital problems
- ☐ Trouble sleeping
- ☐ Panic attacks
- ☐ Anxiety
- ☐ Thoughts of harming others

Skin

- ☐ Change in nails
- ☐ Lumps
- ☐ Recurrent rashes
- ☐ Sores that will not heal
- ☐ Moles that are changing

Ears

- ☐ Hearing loss
- ☐ Ringing
- ☐ Earache
- ☐ Feeling of ear fullness

Mouth and Throat

- ☐ Dry mouth
- ☐ Sore throat
- ☐ Mouth ulcers
- ☐ Hoarseness
- ☐ Dental issues

Endocrine

- ☐ Unusual heat intolerance
- ☐ Unusual cold intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger

Urinary

- ☐ Pain/burning with urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Trouble starting to urinate
- ☐ Waking up to urinate
- ☐ Leaking of urine
- ☐ Change in stream

Nervous System

- ☐ Headaches
- ☐ Seizures/convulsions
- ☐ Fainting spells
- ☐ Frequent memory loss
- ☐ Weakness
- ☐ Shakiness or tremor
- ☐ Loss of sensation/numbness
- ☐ Feeling of tingling in limb
- ☐ Speech difficulty

Nose and Sinuses

- ☐ Bleeding
- ☐ Nasal congestion
- ☐ Sneezing
- ☐ Loss of sense of smell

Neck

- ☐ Pain
- ☐ Lumps

Cardiovascular

- ☐ Abnormal heart beat
- ☐ Chest pain
- ☐ Passing out
- ☐ Shortness of breath
- ☐ Swelling of ankles
- ☐ Leg pain/resting
- ☐ Leg pain/walking

Gastrointestinal

- ☐ Unable to eat certain foods
- ☐ Loss of appetite/weight
- ☐ Food sticks in throat
- ☐ Painful swallowing
- ☐ Heartburn
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting blood
- ☐ Abdominal/stomach pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Recent change in bowel habits
- ☐ Blood in stools
- ☐ Black stools

Musculoskeletal

- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Muscle soreness

Blood disorders

- ☐ Easy bruising
- ☐ Excessive bleeding