Pinehurst Medical Clinic

Primary Care New Patient Questionnaire

Demographics:

MRN: ____________________

Name____DOB______________________

Emergency Contact relationship and phone number_______________________________________

Other providers/specialists involved in your care____

Social History:

Tobacco Use: ☐ Cigarettes/cigars ☐ snuff/chewing tobacco ☐ Vapor

☐ Current use packs per day________ how many years_______ ☐ previous use quit date______________

☐ Never a user

Alcohol Use: ☐ none ☐ drinks per day/week__________________Marijuana use ☐ yes ☐ no

Other Recreational drugs if applicable: ____

Marital Status: ☐ Married ☐ single ☐ widowed/divorced Children if yes how many_________

Who lives with you? ____

Medical History:

*Include all over the counter medications and vitamins

Allergies/ Reactions:

Current Medications	Strength	How often taken	who prescribes

Current and past Medical Issues:

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

Family History:

	cancer	Lung problems	High Blood Pressure	Diabetes	Heart Problems	stroke	unknown
Self							
mother							
father							
Grandmother/grandfather paternal							
Grandmother/Grandfather maternal							
Great- Maternal Grandmother/grandfather							
Great- Paternal Grandmother/Grandfather							
Sister							
Brother							
Aunt							
Uncle							

Prevention:

*Please check all that apply with most recent date and performing provider

Tetanus_________________________________ Colonoscopy_____________________________________

Pneumonia Vaccine ______________________ Cholesterol Level Test___________________________

Flu Vaccine ______________________________ Eye Exam____

Hepatitis B Series ________________________ Mammogram ____________________________________

Prevnar_________________________________ Shingles Vaccine ________________________________

Pap Smear_______________________________Tuberculin skin test ____________________________

Do you exercise regularly? ☐ Yes ☐ No How many falls have you had in the last year? _______

Do you feel safe in your home? If no, why? ______________________________________

Surgical History:

*List all the surgeries that you have had with the year and performing physician

__________________ __________________ __________________

__________________ __________________ __________________

__________________ __________________ __________________

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Review of Systems: *Please check all that apply

Constitutional		**Skin**		**Gastrointestinal**	
Fever/chills		Changes in moles		Hepatitis	
Weight loss		Rash/lesions		Constipation	
Hematologic		Nipple discharge		Diarrhea	
Bleeding disorders		Breast abnormalities		Bloody stools	
Endocrine		**Neurological**		Nausea/vomiting	
Diabetes		Neurological problems		Reflux	
Thyroid problems		Headaches		Liver problems	
Musculoskeletal		**Genitourinary**		**Cardiovascular**	
Mobility/joint problems		Genital or oral herpes		High Blood Pressure	
Arthritis		S.T.D.'s		Heart problems	
Eyes		Kidney problems		Blood clots	
glaucoma		Prostate problems		DVT/deep vein thrombosis	
Other eye problems		Blood in urine		**Respiratory**	
ENT		Last Menstrual Period		Lung problems	
Sinus problems		Urinary tract infections		Asthma	
Hearing problems		Problems urinating		Sleep apnea	
Dizziness		**Psychiatric**			
		Mood swings			
		Anxiety/depression			

If yes, please describe:

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