Khair Family Practice

New Patient Questionnaires

Name: _____

DOB: _____ Act#: _____

Date: _____

New Patient Intake

Email: _____ **Phone #:** _____ **Address:** _____

Reason for Visit: _____

Current Medications (Prescription and Over-the-Counter):

_____

_____

_____

_____

_____

ALLERGIES: (Please list all known allergies with type of reaction. Example: "amoxicillin - rash, cat dander - sneezing, losartan - cough")

_____

_____

_____

_____

Pharmacy: _____ City: _____ Cross Streets: _____ Phone #: _____

(Please list reason with date to include the month and year if possible. Only list hospitalizations that are not included in surgical history.)

Surgical History:

Reason	Date

Hospitalization History:

Reason	Date

Preventive Medicine

Please complete the below questions as accurately as possible. Thank you.

Colonoscopy: Have you ever had a colonoscopy (ages 45-75)? Yes No

When?_____ Where? _____

Mammogram: Have you ever had a mammogram? Yes No

When?_____ Where? _____

DEXA Scan: Have you ever had a DEXA (bone density) scan (females 65 and older)? Yes No

When?_____ Where? _____

Flu Vaccine: Have you had a flu vaccine this season? Yes No

When?_____

Pneumonia Vaccine: Have you ever had a pneumonia vaccine (65 and older)? Yes No When?_____

Depression:

Are you depressed? Yes No

In the last 2 weeks have you been bothered by having little interest or pleasure in doing things? Yes No

In the last 2 weeks have you been bothered by feeling down, depressed, or hopeless? Yes No

Diabetes: Are you diabetic? Yes No

If yes, have you had a diabetic eye exam in the last 2 years? Yes No

If yes, what was the date and result of your last Hemoglobin A1c? Date:_____ Result:____

Fall Risk Screening/History: (circle one)

None in the past year

One fall with injury in the past year

Two or more falls with injury in the past year

One fall without injury in the past year

Two or more falls without injury in the past year

Past Medical History

Select the diagnosis below ONLY if it applies to your medical history. If you have a diagnosis not listed here, please select "other" and the medical staff will address it during your visit. If you do not have any medical diagnosis, please select "none".

- ❑ acid reflux.
- ❑ allergies, seasonal.
- ❑ anemia.
- ❑ anxiety.
- ❑ aortic stenosis.
- ❑ arthritis.
- ❑ asthma.
- ❑ Barretts esophagus.
- ❑ bipolar disorder.
- ❑ bladder incontinence.
- ❑ blood clot.
- ❑ cancer, breast.
- ❑ cancer, colon.
- ❑ cancer, lung.
- ❑ cancer, prostate.
- ❑ cancer, other.
- ❑ cardiac arrhythmia (A-fib, AV-block, left/right bundle branch block).
- ❑ chronic obstructive pulmonary disease (COPD).
- ❑ congestive heart failure.
- ❑ coronary artery disease (heart disease).
- ❑ dementia.
- ❑ depression.
- ❑ diabetes, type I.
- ❑ diabetes, type II.
- ❑ elevated Cholesterol.
- ❑ enlarged prostate.
- ❑ fatty liver.
- ❑ gallstones.
- ❑ GI disorder.
- ❑ glaucoma.
- ❑ gout.
- ❑ heart murmur.
- ❑ hernia.
- ❑ hypertension (high blood pressure).
- ❑ kidney stones.
- ❑ lactose intolerance.
- ❑ migraine headaches.
- ❑ organ transplant.
- ❑ osteoporosis.
- ❑ pacemaker.
- ❑ renal artery stenosis.
- ❑ renal failure.
- ❑ schizophrenia.
- ❑ sexual dysfunction.
- ❑ sleep apnea.
- ❑ spinal stenosis.
- ❑ stroke.
- ❑ thyroid disorder.
- ❑ thyroid nodule.
- ❑ vertigo.
- ❑ vitamin B12 deficiency.
- ❑ vitamin D deficiency.
- ❑ white coat hypertension (high blood pressure in doctor's office).
- ❑ other.
- ❑ none.

Family History

	Father	Mother	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother	Sibling(s)	Children
Alive								
Deceased								
Heart Disease								
High Blood Pressure								
Stroke								
Cancer								
Glaucoma								
Diabetes								
Epilepsy								
Bleeding Disorder								
Kidney Disease								
Thyroid Disease								
Mental Illness								
Osteoporosis								
History Unknown								

Social History

Caffeine (coffee, soda, teas, etc.) : none 1-2 cups per day 3-4 cups per day 5+ cups per day

Exercise (intentional exercise outside of your normal activity): none 1-2 days per week 3-4 days per week 5+ days per week

Marital status: Single Married Widowed

Occupational exposure to blood or bodily fluids: Yes No

Sex at Birth: Male Female Gender Identity: _____ Sexually active: Yes No Prefer Not to Answer

Alcohol Screen:

1. Did you have a drink containing alcohol in the past year? Yes No
2. How often did you have 6 or more drinks on one occasion in the past year? Never (0 point) Less than monthly (1 point) Monthly (2 points) Weekly (3 points) Daily or almost daily (4 points)
3. How many drinks did you have on a typical day when you were drinking in the past year? 1 or 2 drinks (0 point) 3 or 4 drinks (1 point) 5 or 6 drinks (2 points) 7 to 9 drinks (3 points) 10 or more drinks (4 points)
4. How often did you have a drink containing alcohol in the past year? Never (0 point) Monthly or less (1 point) 2 to 4 times a month (2 points) 2 to 3 times a week (3 points) 4 or more times a week (4 points)

Tobacco Screen:

Smoking Status: Current Smoker Former Smoker Never Smoked Uses tobacco in other form (_____)

Number of Years: _____ Packs Per Day: _____ Year Stopped Smoking:_____

Female Health

We ask that all those with sex assigned female at birth complete the section regarding GYN history. In regards to sections Menstruation and OB history, please only answer if the section applies to you. Thank you.

GYN History:

Last mammogram date: _____

Hysterectomy? None Radical Total Partial

Last pap smear date: _____

History of Abnormal Pap Smear? Yes No

Any history of Sexually Transmitted Diseases (STDs)? Yes No

Birth Control? Yes No Abnormal menstruations? Yes No

Date of Last Period if Not in Menopause: _____

If applicable, Menopause Began at Age: _____

OB History:

Total pregnancies: ____ Total living children: ____

History of NVD (Normal Vaginal Delivery)? Yes No

History of C section(s)? Yes No

Menstruation:

Time since last menstrual period:

menopause 1-2 months > 2 months

Period Lasts: > 7 days 2-7 days 1 day

Time between periods:

- ❑ irregular
- ❑ > 45 days apart
- ❑ 33 to 45 days apart
- ❑ 21 to 32 days apart
- ❑ < 21 days apart

Character of period: heavy light

- ❑ with severe pain
- ❑ with moderate pain
- ❑ with mild discomfort
- ❑ without discomfort/pain