link COMMUNITY CLINIC

NEW PATIENT HEALTH QUESTIONNAIRE

Last Name, First Name (Preferred): _____ **DOB:** _____

For the following three items, check all that apply.

Pronouns ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs ☐ not listed _____

Current gender identity ☐ woman ☐ man ☐ transwoman ☐ transman ☐ nonbinary ☐ not listed_____

Sex assigned at birth ☐ male ☐ female ☐ intersex ☐ not listed _____

For the following three tables, if you need additional space, please feel free to use the back of page 3.

Allergies *(Please list all food and drug allergies along with the reaction you experienced.)*

Food or Drug Allergies	Reaction

Medications *(Please list all prescription and over-the-counter medications with their doses and frequency.)*

Medication	Dose	Frequency

Supplements/Vitamins *(Please list all supplements or vitamins with their doses and frequency.)*

Supplement/Vitamin	Dose	Frequency

Home and environment *(Please check all that apply.)*	
Are you a caregiver?	☐ Yes ☐ No
Do you have any pets?	☐ Yes ☐ No
Are you passively exposed to smoke?	☐ Yes ☐ No
Are there any guns present in your home?	☐ Yes ☐ No

Past and current medical conditions *(Please check or list any medical problems you have experienced).*		
☐ Abnormal Bleeding	☐ COPD	☐ Ear/Hearing Problems
☐ Acid Reflux (GERD)	☐ Cardiomyopathy	☐ Epilepsy/Seizures
☐ AIDS/HIV	☐ Aneurysm	☐ Diabetes
☐ Allergies	☐ Congestive Heart Failure	☐ Fibromyalgia
☐ Anemia	☐ Gastrointestinal Disease	☐ Gestational Diabetes
☐ Headaches	☐ Hepatitis/Liver Disease	☐ High Cholesterol
☐ Hypertension	☐ Hyperthyroidism	☐ Hypothyroidism
☐ Kidney Disease	☐ Mental Illness	☐ Migraines
☐ Neurological Disorder	☐ Neuropathy	☐ Osteoporosis/Osteopenia
☐ PCOS	☐ Pacemaker	☐ Peripheral Vascular Disease
☐ Pulmonary Embolism	☐ Rheumatoid Arthritis	☐ Sleep Apnea
☐ Stroke	☐ Cancer	☐ Eczema
☐ Abnormal Pap Smear	☐ Other _____	

Surgical History/Hospitalizations *(Please note all previous surgeries or hospitalizations and the year they occurred.)*		
☐ Abdominal Surgery	☐ Bilateral Mastectomy	☐ Joint Replacement
☐ Appendectomy	☐ Caesarean Section	☐ Thyroid Surgery
☐ Back Surgery	☐ Cardiovascular Surgery	☐ Tubal Ligation
☐ ENT Surgery	☐ Vasectomy	
☐ Other _____		

Family History *(Please check or list any diseases that run in your immediate family.)*		
☐ Family history unknown		
☐ Heart disease	☐ Diabetes mellitus	☐ Malignant neoplasm of skin
☐ COPD	☐ Disorder of skin	☐ Malignant tumor of breast
☐ Crohn's disease	☐ Disorder of lung	☐ Multiple sclerosis
☐ Depressive disorder	☐ Disorder of thyroid gland	☐ Osteoporosis
Additional family history:		

Over the last two weeks, how often have you been bothered by any of the following problems? *(Please circl*e)

	Not at all	Several days	More than half the days	Nearly everyday
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, hopeless	0	1	2	3

Health Habits *(Please circle the appropriate answer.)*

Tobacco Use						
Smoking status	I've never smoked		I'm a former smoker		I'm a passive smoker	
	I smoke somedays			I smoke everyday		
How many years have you smoked	< 5	5-10	11-15	16-20	21-25	>25
How many packs per day do you smoke?	¼	½	1	1½	2	3
Have you used e-cigarettes or vape?	Never used		Former user		Current user	
Have you used smokeless tobacco?	Never used		Former user		Current user	
Are you ready to quit?	☐ Yes. ☐ No					
Alcohol Use						
How often do you have an alcoholic drink?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many alcoholic drinks do you typically drink when you are drinking?	1-2	3-4	5-6	7-9	10+	
Note the number of each item you drink per week	Glass of wine_____		Cans/bottles of beer_____		Shots of liquor_____	
Recreational drug use						
Do you use recreational drugs? ☐ No ☐ Yes (please specify)						
Physical Activity						
How many days in a week do you engage in strenuous physical activity (walking, running, swimming, dancing) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7						
Sexual History						
Are you Sexually Active?	☐ Yes ☐ No					
Partners?	☐ Male ☐ Female ☐ Both ☐ Other _____					
Do you use anything to prevent pregnancy in yourself or your partners?	☐ No ☐ Yes	☐ If yes, what type? _____				

Thank you for your time. Your medical history is important to us!