

NEW PATIENT ADULT COMPREHENSIVE HEALTH ASSESSMENT

Please answer these questions to help us maintain accurate records and provide high quality care. All information will be kept confidential. Please discuss any questions about these items with your doctor or clinical staff.

Patient Name:

DOB:

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

Do you have any special hearing needs? ☐ Yes ☐ No

Do you have vision impairment? ☐ Yes ☐ No

Preferred Pharmacy

Name:

Location:

Number:

Medications

Please list all your MEDICATIONS (prescriptions, over the counter, vitamins, herbal supplements). Include the dose and frequency for each.

Drug Name

Dosage

Drug Name

Dosage

Allergies

Do you have any allergies to medications, foods, or other substances? If yes, please list each and the reaction you've experienced.

Allergic to

Reaction

Allergic to

Reaction

Chronic Conditions / Past Medical History

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Heart Attack / MI
- ☐ Heart Failure / CHF
- ☐ Depression
- ☐ Anxiety
- ☐ Cancer (Please list type below)

- ☐ Pneumonia
- ☐ COPD/Emphysema/Bronchitis
- ☐ Asthma
- ☐ Tuberculosis / TB
- ☐ Sexually Transmitted Infection
- ☐ Other Sexual Problems
- ☐ Abnormal Pap Smear
- ☐ Prostate Problems

- ☐ Urinary Tract Infection / UTI
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Thyroid Disease
- ☐ Allergies / Hay Fever
- ☐ Blood or Bleeding Disorders
- ☐ Anemia
- ☐ Hepatic / Liver Disease

- ☐ Hemorrhoids
- ☐ Gastrointestinal Ulcers
- ☐ Diverticulitis or Diverticulosis
- ☐ Heartburn / Reflux Problems
- ☐ Arthritis / Joint Problems
- ☐ Skin Disease
- ☐ Drug Problems
- ☐ Alcohol Problems

☐ **Other** (Please explain below)

Cancer:

Other:

Surgical History

Please list all OPERATIONS you have had and give the approximate DATE of each:

Operation

Date

Operation

Date

- ☐ Appendectomy
- ☐ Cholecystectomy (gallbladder out)
- ☐ Hysterectomy
- ☐ Heart surgery

- ☐ Joint surgery

Hospitalizations

Please list the diagnosis/reason for all HOSPITALIZATIONS you have had and give the approximate DATE of each:

Diagnosis/Reason

Date

Diagnosis/Reason

Date

PLEASE TURN OVER AND COMPLETE SIDE 2

Patient Name: _____

DOB: _____

Diagnostic Studies (for example: stress tests, echocardiograms, CAT scans, MRIs)

Please list all DIAGNOSTIC STUDIES you have had and give the approximate DATE of each:

<u>Study</u>	<u>Date</u>	<u>Study</u>	<u>Date</u>
☐ Heart Stress Test	_____	_____	_____
☐ Echocardiogram	_____	_____	_____
☐ Heart Catheterization	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History

Has anyone in your IMMEDIATE family had any of the following illnesses?

<u>Illness</u>	<u>Family Member / Age Diagnosed</u>	<u>Illness</u>	<u>Family Member / Age Diagnosed</u>
Cancer (list type)	_____	Suicide / Suicide Attempt	_____
High Blood Pressure	_____	Asthma	_____
High Cholesterol	_____	Osteoporosis / Thinning Bones	_____
Diabetes	_____	Glaucoma	_____
Heart Attack / MI	_____	Kidney Disease	_____
Stroke or Mini-Stroke / TIA	_____	Bleeding Disorder	_____
Depression / Bipolar	_____	Genetic Disorder	_____
Drug/Alcohol Problems	_____	Other (list type)	_____

Is your mother alive? ☐ Yes ☐ No If not, age at death and cause of death: _____
Is your father alive? ☐ Yes ☐ No If not, age at death and cause of death: _____

Social / Occupational History

Present Occupation? _____
Previous Occupation? _____
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? If so, which ones?

Have you ever been exposed to any environmental hazards such as radiation, toxic waste, or lead paint? If so, which ones?

Lifestyle / Safety

Do you use tobacco products? ☐ Yes ☐ No If yes, what kind? _____ How much? _____
Do you drink alcohol? ☐ Yes ☐ No If yes, what kind? _____ How much per week? _____
Do you drink caffeine? ☐ Yes ☐ No If yes, what type / how much? ☐ coffee _____ ☐ tea _____ ☐ soda _____
Do you exercise? ☐ Yes ☐ No If yes, what type / how much? ☐ cardio ☐ weights ☐ swim _____
Do you follow a particular diet? ☐ Yes ☐ No ☐ low fat ☐ low salt ☐ low carbohydrate ☐ vegetarian ☐ vegan ☐ gluten-free
Do you have smoke detectors? ☐ Yes ☐ No
Do you have a gun in your house? ☐ Yes ☐ No If yes, is it under lock and key? _____
Do you wear a seatbelt? ☐ Yes ☐ No
Have you travelled outside the U.S.? ☐ Yes ☐ No If yes, where? _____

Answering the following questions will help us provide the best possible care. Your answers will be confidential.

Do you use drugs? (Cocaine, marijuana, opiates, etc.) ☐ Yes ☐ No If yes, what type? _____
Have you been sexually active? ☐ Yes ☐ No If yes, with ☐ men ☐ women ☐ both
How many sexual partners have you had? currently _____ lifetime _____
Do you practice safe sex? ☐ Yes ☐ No If yes, what method of protection do you use? _____
Do you use condoms? ☐ Yes ☐ No If yes, how often do you use them? ☐ Always ☐ Sometimes
Do you use other contraception? ☐ Yes ☐ No If yes, what? ☐ birth control pills ☐ IUD ☐ sponge
☐ diaphragm ☐ rhythm method

PLEASE COMPLETE SIDE 3

Patient Name:

DOB:

Health Maintenance

When was your LAST (Please give approximate date):

Pap Smear _____
Breast Exam _____
Mammogram _____
DEXA Scan _____

Prostate Exam / PSA _____
Stool Check for Blood _____
Colonoscopy Exam _____
Cholesterol Check _____
Complete Physical _____

Immunizations

Have you had any of these IMMUNIZATIONS?

Influenza/Flu ☐ No ☐ Yes, Date: _____
Tetanus/Td alone ☐ No ☐ Yes, Date: _____
Tetanus with Pertussis/Tdap ☐ No ☐ Yes, Date: _____
Pneumonia/Pneumovax ☐ No ☐ Yes, Date: _____

Hepatitis B ☐ No ☐ Yes, Date: _____
HPV/Cervical Cancer ☐ No ☐ Yes, Date: _____
Zoster/Shingles ☐ No ☐ Yes, Date: _____
Meningococcal ☐ No ☐ Yes, Date: _____

Patient Health Questionnaire (PHQ-2): Please circle your response.

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	<u>Not at All</u>	<u>Several Days</u>	<u>More Than Half the Days</u>	<u>Nearly Every Day</u>
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3