ARCTURUS HEALTHCARE

Clearwater Family Medicine

New Adult Patient Questionnaire

Name:	Appointment Date:
Birthdate:	Current Age:

Please mark any **illness or disease** you have had in the past or currently have:

_____Diabetes (Sugar)
_____High Cholesterol
_____Thyroid Disease

_____High Blood Pressure
_____Heart Attack
_____Angina / Chest Pain
_____Congestive Heart Failure
_____Other Heart Disease
_____Other Lung Disease

_____Hiatal Hernia
_____Liver Disease
_____Stomach Ulcers
_____Disease of the Colon
_____Hemorrhoids

_____Kidney Disease
_____Bladder Problems
_____Prostate Problems

_____Asthma
_____Chronic Bronchitis
_____Emphysema
_____Allergies
_____Pneumonia
_____Ear Problems

_____Stroke
_____Seizures / Epilepsy
_____Accidents / Broken Bones
_____Head Injury

_____Depression
_____Anxiety
_____Psychiatric Illness

_____Arthritis
_____Osteoporosis
_____Gout
_____Back Problems
_____Eye Problems

_____Bleeding / Clotting
_____Disorder
_____Anemia
_____Cancer (Specify_____)
_____Other (Specify_____)

Please list any **operations or surgeries** you have had along with the *date* and *reason* for the surgery.

Do you have any **allergies** to any **medications**, food, latex, or environmental stimuli? What *happens*?

Please list your **current medications** including any **over the counter medications, vitamins, or herbal remedies,** you take regularly. Please include the *dose* if you know it also.

Please list any **other doctors** you see and their **specialty**.

Do you **smoke** tobacco? If so, how much do you smoke, and how long have you been a smoker?

Do you **drink alcohol**? If so, how much, and how often do you drink?

Continued on other side

Immunizations protect us from illness. Which of the following immunizations have you had?
Please list the *approximate date* of the last immunization you received.

Tuberculosis _____ Tetanus _____
Rubella _____ Pneumonia _____
Influenza (flu) _____ Hepatitis (A/B) _____
Chickenpox _____

What **diagnostic and screening studies** have you had done previously? Please list the most **recent** *date.*

Last Complete Physical Exam _____ Chest X-Ray _____
Electrocardiogram (EKG) _____ Cardiac Stress Test _____
Sigmoid / Colonoscopy _____ Cholesterol _____
Stool Occult Blood Test _____ Mammogram _____
Prostate (PSA) _____ Pap Smear _____

Please list your **current occupation**, and any other **previous jobs** you have held. Please comment on any **job related illnesses**, or **harmful material exposures.**

_____ _____
_____ _____

For Women Only:

How old were you when you had your first period? _____ # of pregnancies _____
How many days pass between your cycles _____ # of live births _____
How long do your periods last? _____ Premature births _____
Are your periods irregular? _____ # of abortions _____
What was the date of your last period? _____ Miscarriages _____
Any abnormal paps? _____ Living Children _____

Please list your **family members** and any **illnesses** they have had in the past.

	Relatives' Names	**Yr of Birth**	**Yr of Death**	**Age at Death**	**Illness / Status of Health**
Father					
Mother					
Brothers/					
Sisters					
Children					
Others					

Please write any **additional problems, concerns,** or **information** about you or your family that you would like your health care provider to know:

_____
_____

Patient Signature: _____ **Physician Signature** _____