AFFINITY HEALTH GROUP

New Patient History Questionnaire

Name: _____ DOB: _____ Date: _____

Please check all that apply

REVIEW OF SYSTEMS

In the past 4 weeks have you had any of the following?

☐ Fever
☐ Headache
☐ Sore Throat
☐ Cough
☐ Chest Pain
☐ Palpitations
☐ Shortness of Breath
☐ Abdominal Pain
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Burning Urination
☐ Difficulty Urinating
☐ Depression
☐ Cognitive Deficit
☐ Vision Deficit: ☐Glasses ☐Contacts ☐Other _____
☐ Hearing Deficit: ☐Hearing aid(s) ☐Deaf
☐Cochlear implant ☐Other _____
☐ Other: _____

PAST MEDICAL HISTORY

Have you ever had any of the following illnesses/problems?

☐ Abnormal Pap
☐ Alcoholism
☐ Alzheimer's
☐ Angina (chest pain)
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Anemia
☐ Bipolar Disorder
☐ Blindness
☐ Blood Clot / DVT
☐ CVA / Stroke
☐ Coronary Artery Disease
☐ Congestive Heart Failure
☐ COPD (Chronic Obstructive Pulmonary Disease)
☐ Cancer
☐ Heart Disease
☐ Coumadin Usage
☐ Depression
☐ Dementia (memory loss)
☐ Diabetes
☐ Diverticulosis / Diverticulitis
☐ End Stage Renal Disease (w/ dialysis)
☐ End Stage Renal Disease / Chronic Renal Failure (w/o dialysis)

PAST MEDICAL HISTORY CONTINUED

☐ Gastrointestinal Bleed
☐ Gastroesophageal Reflux Disease
☐ Glaucoma
☐ HIV / AIDS
☐ Hyperlipidemia (high cholesterol)
☐ Hypertension (high blood pressure)
☐ Kidney Disease
☐ Kidney Stone
☐ Liver Disease / Hepatitis
☐ Lupus
☐ Myocardial Infraction (heart attack)
☐ Menopause
☐ Mental Illness
☐ Osteoporosis
☐ Peripheral Edema (swelling of legs)
☐ Peripheral Vascular Disease/Peripheral Artery Disease
☐ Rheumatoid Arthritis
☐ Schizophrenia
☐ Seizure Disorder
☐ Sickle Cell
☐ Substance Use Disorder
☐ Suicidal Behavior
☐ Transient Ischemic Attack (mini-stroke)
☐ Thyroid Disorder
☐ Tuberculosis
☐ Urinary Tract Infection – Recurrent
☐ Other: _____

In the last 30 days have you had the following?

☐ Physical Therapy ☐ Home Health
☐ Occupational Therapy ☐ Hospice
☐ Speech Therapy ☐ Out-Patient Mental Health
☐ Radiation or Chemo ☐ Mental Health Hospital

PAST SURGICAL HISTORY

Have you had any of the following surgeries?

☐ Adenoidectomy (adenoids removed)
☐ Above the Knee Amputation
☐ Below the Knee Amputation
☐ Abdominal Surgery
☐ Coronary Artery Bypass Grafting
☐ Cholecystectomy (gallbladder removed)
☐ Heart Surgery
☐ Joint Replacement
☐ Ear Nose or Throat Surgery
☐ Mastectomy: ☐ Bilateral ☐ Unilateral
☐ Hysterectomy: ☐ Cervix Removed ☐ Have Cervix
☐ Pressure Equalizer Tubes (ear tubes)

PAST SURGICAL HISTORY CONTINUED

☐ Prosthetic Surgery
☐ PTCA / PCI (angioplasty)
☐ Spinal Surgery
☐ Thyroid Surgery
☐ Tonsillectomy (tonsils removed)
☐ Tubal Ligation (tubes tied)
☐ Vascular Surgery
☐ Problems with Anesthesia: ☐ Yes ☐ No
☐ Complications with Surgery: ☐ Yes ☐ No
☐ Delirious after Surgery: ☐ Yes ☐ No
☐ Other: _____

FAMILY HISTORY

Please mark all that apply and write relationship to you.

☐ Alcoholism _____
☐ Asthma _____
☐ Bipolar Disorder _____
☐ Breast Cancer _____
☐ Colon Cancer _____
☐ COPD _____
☐ Depression _____
☐ Diabetes _____
☐ Hypertension _____
☐ Lung Disease _____
☐ Migraines _____
☐ Osteoporosis _____
☐ Respiratory Disease _____
☐ Prostate Cancer _____
☐ Bladder/Kidney Cancer _____
☐ Kidney Stones _____
☐ Kidney Disease _____
☐ Genetic Diseases _____
☐ Schizophrenia _____
☐ Sickle Cell Disease/Trait _____
☐ Substance Use Disorder _____
☐ Suicide _____
☐ Other: _____

RISK FACTORS

Have you been hospitalized within the last 30 days?

☐ Yes ☐ No
If Yes:
Which hospital? _____
When were you discharged? _____
Did anyone contact you within 2 business days of being discharged? ☐ Yes ☐ No

Have you used Tobacco products?

☐ Currently ☐ Previously ☐Never
If Currently: How often? _____
Year Started _____
Product used: ☐ Cigarettes ☐ Cigars ☐ Smokeless/chewing

Does anyone smoke around you?

☐ Yes ☐ No

RISK FACTORS CONTINUED

Do you drink alcohol?

☐ Yes ☐ No
If Yes:
How often? _____
Type of alcohol _____
Have you ever felt the need to cut down? ☐ Yes ☐ No
Have you been annoyed by complaints? ☐ Yes ☐ No
Have you felt guilty regarding drinking? ☐ Yes ☐ No
Do you need an eye opener in the morning? ☐ Yes ☐ No
Comments: _____

Do you use illegal substances?

☐ Yes ☐ No
If Yes: Comments: _____

Are you at high risk for HIV?

☐ Yes ☐ No
If Yes: Comments: _____

How many caffeinated beverages do you drink a day?

_____

How often do you use your seatbelt?

☐ 100% ☐75% ☐50% ☐ 25% ☐ 0%

How many times per week do you exercise?

_____

How often do you get sun exposure?

☐ Frequently ☐ Occasionally ☐Rarely

Have you broken any bones in the last year?

☐ Yes ☐ No

Have you fallen in the last year?

☐ Yes ☐ No

Have you had any trouble urinating in the last 6 months?

☐ Yes ☐ No

Over the past 2 weeks, have you felt down, depressed, or hopeless? ☐ Not at all ☐ Several days ☐ More days than not ☐ Nearly every day

Over the past 2 weeks, have you felt little interest or pleasure in doing things? ☐ Not at all ☐ Several days ☐ More days than not ☐ Nearly every day

Have any females under the age of 65 in your family ever had a heart attack? ☐ Yes ☐ No

Have any males under the age of 55 in your family ever had a heart attack? ☐ Yes ☐ No

Do you have a living will?

☐ Yes ☐ No

Do you have a durable power of attorney?

☐ Yes ☐ No
If Yes: Who? _____