CANISTEO VALLEY FAMILY PRACTICE
NEW PATIENT QUESTIONNAIRE

Name _____ DOB _____

Patient History

Please check if you have or have had any of the following:

COPD ___
Asthma ___
Seasonal Allergies ___
Heart Murmur ___
History of Heart Attack ___
History of Stroke ___
History of Seizure ___
High Blood Pressure ___
Pacemaker ___
Breast Lumps/Discharge ___

Varicose Veins ___
Diabetes ___
Thyroid Disorder ___
Depression ___
Anxiety ___
Post Menopausal ___
History of Cancer ___
where_____
Heavy Periods ___

Medications: **Dosing and Frequency:**

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please use separate sheet if you run out of space.

Medication Allergies: **Reaction:**

_____
_____
_____
_____

Surgical History:

_____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____

Fractures – Please add location of fracture:

_____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____

Hospitalizations other than surgeries:

_____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____

Please answer if applicable.

When was your last: **Where done:**

Dental Exam _____
Eye Exam _____
Colonoscopy _____
Mammogram _____
PAP Smear _____

Menses _____

Family History:

Father: **Age_____** **Alive ___** **Deceased ___** □

□ **Cancer __** **Heart Disease __** **Stroke __** **Diabetes __** □ **High Blood Pressure __**
□ **Liver Disease__** □ **High Cholesterol __** □ **Thyroid Disease __**□ **Seizures __**
□ **Alcohol Abuse __** □ **Drug Abuse __**□ **Depression/Psychiatric Illness __**

Mother: **Age_____** **Alive ___** **Deceased ___** □

□ **Cancer __** **Heart Disease __** **Stroke __** **Diabetes __** □ **High Blood Pressure __**
□ **Liver Disease__** □ **High Cholesterol __** □ **Thyroid Disease __**□ **Seizures __**
□ **Alcohol Abuse __** □ **Drug Abuse __**□ **Depression/Psychiatric Illness __**

Siblings: **Number _____** **Brothers _____** **Sisters ____**

□ **Cancer __** **Heart Disease __** **Stroke __** **Diabetes __** □ **High Blood Pressure __**
□ **Liver Disease__** □ **High Cholesterol __** □ **Thyroid Disease __**□ **Seizures __**
□ **Alcohol Abuse __** □ **Drug Abuse __**□ **Depression/Psychiatric Illness __**

Children: **Number _____** **Male _____** **Female _____** **Age Range _____**

Cancer __ **Heart Disease __** **Stroke __** **Diabetes __** □ **High Blood Pressure __**
□ **Liver Disease__** □ **High Cholesterol __** □ **Thyroid Disease __**□ **Seizures __**
□ **Alcohol Abuse __** □ **Drug Abuse __**□ **Depression/Psychiatric Illness __**

Social History:

Smoking Status:

□ **Current Smoker ___ Former Smoker___□ Nonsmoker___**

If you are
a former smoker, how long has it been since you last smoked?

□ **1-3 mos ___ 3-6 mos ___ 6-12 mos ___ 1-5 yrs ___ 5-10 yrs ___ over 10 yrs ___**

If you are a current smoker, do you smoke:

□ **Daily ___ □ Somedays ___**

How many cigarettes do you smoke in a day?

□ **5 or less ___ □ 6-10 ___ □ 11-20 ___ □ 21-30 ___ □ 31 or more ___**

Patient uses other tobacco products:
□
Yes ___ No ___ If yes, please list: _____
_____

Have you used drugs other than those for medical reasons in the past 12 months?

□ **Yes ___ No ___ If yes, please list: _____**
_____

How often do you drink alcohol?

□ **Daily ___ □ Weekly ___ □ Monthly ___ Never ___**

Do you have any concerns you would like to bring up with your provider today?
_____
_____
_____
_____
_____

Please bring completed form with you to your first appointment.
Thank you.