East Valley
FAMILY
Physicians P.L.C.
Serving the Valley for Over 30 Years

New Patient Questionnaire for Primary Care

Name:_____

DOB:_____ Marital Status:_____

Address:_____

Home Phone:_____ Cell Phone:_____

Reason for visit:_____

Specialists:

Name	Phone	Date last seen

Allergies

Medical	**Reaction**	**Food**	**Reaction**

Health Screenings (recent)	**Where**	**Year**	**Normal**		**Explain**
Bone Density test			Yes	No	
Cholesterol Level			Yes	No	
Colonoscopy			Yes	No	
Diabetes Test			Yes	No	
Prostate Check			Yes	No	
Eye Exam			Yes	No	
Mammogram			Yes	No	
Pap Smear			Yes	No	

New Patient Questionnaire for Primary Care *(continued)*

Immunizations	**Yes**	**No**	**Year**
TD			
TDAP			
MMR			
Pneumonia			
Hepatitis A			
Hepatitis B			
Shingles			
Prevnar			
Flu			

Please list the medications you are currently taking

Medication name	**Dose**	**Units (MG)**	**How often**	**Start Date**	**End Date**

New Patient Questionnaire for Primary Care *(continued)*

Medical History: *(check if you have ever had or been diagnosed with any of the following)*

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis (rheumatoid)
- ☐ Arthritis (osteo.)
- ☐ Bipolar
- ☐ Cancer-_____ _____
- ☐ Constipation
- ☐ Chronic Lung Disease
- ☐ Deep Venous Thrombosis
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Fibrocystic Breast Disease
- ☐ Gallstones
- ☐ Hard of Hearing
- ☐ Heart-Mitral Valve Prolapse
- ☐ Heart Murmur
- ☐ Heart-Coronary Artery Disease
- ☐ Herpes, Genital
- ☐ Hight Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Infertility
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Mental Illness
- ☐ Migraine Headaches
- ☐ Ovarian Cysts
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Sickle Cell Anemia
- ☐ Sickle Cell Trait
- ☐ Stroke
- ☐ Transfusions
- ☐ Tuberculosis
- ☐ Ulcer (stomach)
- ☐ Urinary Incontinence
- ☐ STD
- ☐ Vision Problems

Social History

Alcohol Use:

- ☐ Never
- ☐ Current
- ☐ Former

Amount used_____
Date Started_____
Date Stopped_____

Tobacco Use:

- ☐ Never
- ☐ Current
- ☐ Former

Amount used_____
Date Started_____
Date Stopped_____