BAPTIST Primary Care

Changing Health Care for Good.®

# Annual Physical New Patient Health Questionnaire

Date _____

Name _____DOB _____

What is your primary concern for today's visit?_____

Name and phone number of your pharmacy?_____

What medications are you allergic to?_____

Please list or attach the name, dosage and frequency of your present medications.

_____ _____

_____ _____

_____ _____

_____ _____

**Check the following symptoms if you have had them over the past two weeks. Considered to be normal if left blank.**

| | | |
|---|---|---|
| __ Unintended weight loss | __ Daytime sleepiness | __ Fever or chills |
| __ Vision changes | __ Runny nose | __ Trouble swallowing |
| __ Heartburn | __ Bowel changes | __ Abdominal pain |
| __ Chest pain | __ Leg swelling | __ Heart palpitations |
| __ Cough | __ Wheezing | __ Shortness of breath |
| __ Urinary frequency | __ Pain with urination | __ Skin changes |
| __ Depressed mood | __ Anxiety | __ Numbness |
| __ Muscle weakness | __ Joint swelling | __ Excessive thirst |
| __ Intolerance to heat or cold | __ Lymph node enlargement | __ Bruising/bleeding |

Are you currently a smoker? _____ Have you ever been a smoker? ___
How many packs do or did you smoke per day? ___ How many years? _____
Check the appropriate marital status. ___ Single ___ Married ___ Divorced ___ Widow
What is your occupation?_____
Please check the amount of alcohol you drink daily. __None __Social __1 __2 __3+
Please check the amount of caffeine servings you use daily. __1 __2 __3 __4+
If you use recreational drugs please list what kind. _____

Please list any prior surgeries and approximate year. _____
_____
_____

**Please list the approximate year you last received the following vaccinations:**

Tetanus ____ Hepatitis A ____ Hepatitis B _____ MMR ____
Pneumovax ____ Influenza ____ Gardasil ____ Varicella ____
Meningitis ____ BCG ____ Shingles/Zostavax ____

**Date of last Colon Cancer Screening _____**

**Women Only**

When was the first day of your last period (or year you started menopause)? _____
Date of Last Pap Smear _____ Year of any abnormal Pap Smear _____
Have you had a hysterectomy? _____ Do you have your ovaries? _____
What are you using for birth control? _____ Date of last mammogram _____
How many pregnancies have your had? _____ Live births?_____ Miscarriages?_____

**Men Only**

Do you wake up to urinate at night? _____ Do you have erectile dysfunction?_____
Explain any history of prostate or testicular problems? _____

**Please check if you or your relative have had the following conditions.**

| | Patient | Mom | Dad | Sibling | Child |
|---|---|---|---|---|---|
| **High blood pressure** | ____ | ____ | ____ | ____ | ____ |
| **Heart Disease** | ____ | ____ | ____ | ____ | ____ |
| **Breast Cancer** | ____ | ____ | ____ | ____ | ____ |
| **Colon Cancer** | ____ | ____ | ____ | ____ | ____ |
| **Diabetes** | ____ | ____ | ____ | ____ | ____ |
| **Ovarian Cancer** | ____ | ____ | ____ | ____ | ____ |
| **Psychiatric Disorder** | ____ | ____ | ____ | ____ | ____ |
| **Drug/Alcohol Abuse** | ____ | ____ | ____ | ____ | ____ |
| **Osteoporosis** | ____ | ____ | ____ | ____ | ____ |
| **High Cholesterol** | ____ | ____ | ____ | ____ | ____ |
| **Lung Disease** | ____ | ____ | ____ | ____ | ____ |
| **Blood Disorders** | ____ | ____ | ____ | ____ | ____ |
| **Thyroid Disorder** | ____ | ____ | ____ | ____ | ____ |
| **Asthma** | ____ | ____ | ____ | ____ | ____ |

**Please list anything else you believe is relevant to your medical health.**

_____
_____
_____