Baptist Primary Care Patient Questionnaire

Name: _____ Date of Birth: _____ Today's Date: _____

Have you provided the office with the most up to date insurance card, driver's license, address, and phone number(s)?

What is the purpose of today's visit? (please list all symptoms)

_____

_____

_____

_____

Please list all known medication allergies: (medication and the reaction)

_____

_____

Are you having regular periods? (Female Patients Only) ☐ Yes First day of your last period _____

☐ No due to Menopause (year) _____ or Hysterectomy (year) _____

What method of birth control do you use?
☐ Not applicable ☐ Pill ☐ Patch ☐ Vaginal Ring ☐ Vasectomy ☐ Tubal ligation (year) _____

Do you consume ***caffeine*** daily? ☐ Yes ☐ No List type and amount consumed each day: _____

Have you ever used, or do you now use any ***Tobacco*** products? ☐ Yes ☐ No Quit (year) _____
If yes for how long, what type, and amount used each day: _____

Have you ever used, or do you now use any ***recreational drugs***? ☐ Yes ☐ No
If yes for how long, what type, and amount used each week:_____

Do you drink alcohol? ☐ Yes ☐ No
If yes for how long, what type, and amount drank each week:_____

Do you exercise? ☐ Yes ☐ No If yes what type and how often each week:_____

Marital Status ☐ Married(Name of Spouse: _____) ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Occupation: _____ Employer: _____

Medications (prescriptions, vitamins, over the counter, etc.)

Name	Strength	How often per day?	Reason for taking?

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

Name: _____ Date of Birth: _____

Have you ever had a sexually transmitted disease? ☐ Yes _____ ☐ No

Obstetrical history: # of Pregnancies: _____ # of deliveries ☐ Vaginal _____ ☐ C-section _____

Immunization History (please list last known date of immunization): Tetanus_____ HPV_____ MMR_____
Flu_____ Shingles_____ Hepatitis A_____ Hepatitis B _____ Pneumonia_____

Preventative Health
☐ Last Colonoscopy (date, location, findings) _____
☐ Last Mammogram (date, location, findings) _____ ☐ Breast implants present
☐ Last Bone Density (date, location, findings)_____
☐ Last Pap smear (date) _____ ☐ any abnormal paps? _____Name of GYN: _____

Are you regularly exposed to any hazardous chemicals or materials at home or work? ☐ Yes ☐ No If yes list duration of daily exposure and type of material(s): _____

Family History (please list immediate family member affected)

☐ Depression/Anxiety:_____ ☐ Asthma:_____
☐ Cancer (type): _____ ☐ Diabetes: _____
☐ Seizures: _____ ☐ Arthritis: _____
☐ Tuberculosis: _____ ☐ Stroke: _____
☐ Heart Disease/Attack:_____ ☐ High/Low Blood Pressure:_____
☐ Kidney Stones/Disease:_____ ☐ Cholesterol: _____
☐ Osteoporosis: _____ ☐ Thyroid Disorder: _____
☐ Alcohol/Drug Use: _____ ☐ Skin Disorders:_____
☐ Other: _____

Surgical and Hospital Past Medical History

Date	Reason for Surgery/Hospitalization

Name of Specialists	***Reason for seeing Specialist***

Please list any additional information about your health that you would like your Physician to know at the time of your examination: _____

_____

_____

_____

_____
Patient's Signature Date

_____
Reviewer Signature Date