Baptist Primary Care – Airport Center
New Patient Questionnaire

Patient Name_____ Today's Date_____
Age:_____ Date of Birth:_____ Phone Number:_____
Most recent Primary Care Provider:_____
Specialist Physicians:_____
_____

What can we do for you today? (Describe any health issues or **reason for visit)**

_____
_____
_____

Please list Current Medications or **Check here if brought in bottles ( )**

Drug	Dose	Frequency	Drug	Dose	Frequency
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		

Past or present **Medical History** (List all medical conditions, e.g. diabetes, hypertension, heart disease, etc.):

_____
_____
_____

Past Surgical History (List all operations):

_____
_____
_____

Allergies and Sensitivities (include reaction – rash, nausea, shortness of breath, other):

_____
_____

Social History (Circle and/or fill-in all that apply)

Marital Status: Single Married with ____children Divorced since _____ Widowed since _____
Living Will: YES NO If yes, do we have a copy? YES NO
Occupation:_____ ( ) Homemaker ( ) Retired
Tobacco: Non-Smoker Currently smoke_____packs/day & have done so for _____years.
Previously smoked____packs/day for___years. Stopped in _____ Smokeless tobacco_____
Alcohol: None/Rarely Social (1-3 per week) Most days 1-2 drinks greater than 2 drinks daily
Daily Caffeine (8 ounce per serving): 0 - 2 3 – 4 over 5 servings daily

Seat Belts: Always Most of the time Never

Family History (Please include history of diabetes, heart disease, high blood pressure or type of cancer):

	Alive(A)/Deceased(D)	Age(s)	Health Problems(if any)/Cause or Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(s)___	_____	_____	_____
Sister(s)_____	_____	_____	_____

No Medical History available _____