CASEY G. BOYER M.D., P.A.

Adult New Patient Questionnaire

Date Completed: _____/_____/_____

PERSONAL INFORMATION

Name: _____ Date of Birth:_____/_____/_____

What is your primary language?_____

Do you have special needs in any of the following areas:

❑ Reading ❑ Vision ❑ Hearing ❑ Mobility (e.g., wheelchair, walker, etc.) ❑ Communication (e.g. need for translator)

HOME

❑ Single ❑ Long-term partner ❑ Married ❑ Civil Union ❑ Divorced ❑ Separated ❑ Widowed

List your children with ages: _____

_____

List current members of your household: _____

EMPLOYMENT

❑ Full-time ❑ Part-time ❑ At home/homemaker ❑ Looking ❑ Disabled ❑ Retired ❑ Student, school:_____

Current occupation: _____ Former occupation (if retired): _____

Employer: ❑ Casey G. Boyer Department:_____ ❑ Other:_____

ALLERGIES List medication allergies and the type of reaction you had. ❑ **I have no drug allergies**

_____ _____

_____ _____

YOUR MEDICAL CONDITIONS (check all that apply)

❑ Allergies
❑ Anemia
❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Blood transfusion
❑ Cancer
❑ Clotting disorder
❑ Congestive heart failure
❑ Depression
❑ Diabetes mellitus
❑ Emphysema/COPD
❑ Gastroesophageal reflux disease (GERD)
❑ Glaucoma
❑ Heart murmur
❑ HIV/AIDS
❑ High cholesterol
❑ Hypertension/high blood pressure
❑ Kidney disease
❑ Myocardial infarction
❑ Nerve/muscle disease
❑ Osteoporosis
❑ Seizures
❑ Sickle cell anemia
❑ Substance abuse
❑ Thyroid disease
❑ Tuberculosis

Details/Other: _____

SURGICAL HISTORY (check all that apply)

- ❑ Appendectomy
- ❑ Brain surgery
- ❑ Breast surgery
- ❑ CABG
- ❑ Cholecystectomy
- ❑ Colon surgery
- ❑ Tonsillectomy
- ❑ Thyroid surgery
- ❑ Lung surgery
- ❑ C-section
- ❑ Eye surgery
- ❑ Fracture surgery
- ❑ Hernia repair
- ❑ Hysterectomy
- ❑ Joint surgery
- ❑ Bunionectomy
- ❑ Varicose vein surgery
- ❑ Prostate surgery
- ❑ Weight reduction surgery
- ❑ Small intestine surgery
- ❑ Spine surgery
- ❑ Tubal ligation
- ❑ Valve replacement
- ❑ Vasectomy
- ❑ Vascular surgery
- ❑ Cardiac stent
- ❑ Bladder surgery

Have you ever had a blood transfusion? ❑ No ❑ Yes, approximate dates _____

FAMILY HISTORY (check all that apply)

	Alcohol abuse	Breast cancer	Ovarian cancer	Prostate cancer	Other cancer(s)	Diabetes	Heart disease	High cholesterol	Hypertension	Mental Illness
Mother										
Father										
Sister										
Brother										
Daughter										
Son										
Other relative										

Other family history: _____

HABITS AND ACTIVITIES

Do you use tobacco? ❑ No ❑ Yes, what form?_____ How much?_____ For how long? _____
❑ In the past, How many years ago did you quit? _____
Have you tried to quit? ❑ No ❑ Yes Would you like to quit? ❑ No ❑ Yes

Do you drink alcohol? ❑ No ❑ In the past ❑ Yes, how many drinks per week? _____

Do you, or have you ever used recreational drugs? ❑ No ❑ Yes, describe:_____

Do you get regular exercise? ❑ No ❑ Yes, what kid of exercise?
How often? ❑ Daily ❑ Weekly ❑ Monthly

List any hobbies or leisure activities:

_____

_____

IMMUNIZATIONS

Vaccination	Approximate Date	Never
Pneumonia (pneumovax)	_____	❑
Tetanus booster (Tdap)	_____	❑
TB skin test (PPD)	_____	❑
Hepatitis B Vaccine	_____	❑
Hepatitis A Vaccine	_____	❑
Varicella (chicken pox)	_____	❑
Shingles (Zostavax)	_____	❑

IMMUNIZATIONS

Test or Procedure	Date and Result	Never
Colonoscopy	_____	❑
Bone density test (DXA)	_____	❑
Cholesterol test	_____	❑
PSA (prostate cancer test)	_____	❑
Pap smear	_____	❑
Mammogram	_____	❑
HIV test	_____	❑

List any abnormal screening test results (e.g. polyps, breast biopsies, etc.):_____

_____

SEXUAL HISTORY

My sexual partners have been: ❑ Male ❑ Female ❑ Both ❑ Never sexually active

Have you had more than one sexual partner in the past year? ❑ No ❑ Yes

Have you ever had a sexually transmitted disease? ❑ No ❑ Yes, what and when? _____

GYNECOLOGICAL AND OBSTETRIC HISTORY

How many times have you been pregnant?_____ Live Births?_____ Miscarriages?_____ Abortions?_____

Do yo use contraception? ❑ No ❑ Yes, what kind? _____

What was your age at first menses? _____ Menstrual periods: ❑ Regular ❑ Irregular ❑ Menopausal

Age at menopause?_____ Do you have hot flashes or other symptoms (specify)?_____

Any gynecological conditions or problems? _____ Name:_____

OTHER HEALTH ISSUES

Do you feel unsafe, or have you been harmed in a physical, emotional or sexual manner, in any relationship or recent encounter?

❑ No ❑ Yes, describe? _____

In the past year, have you had two weeks or more during which you felt sad, blue or depressed or when you have lost all interest or pleasure in things you usually care about or enjoyed? ❑ No ❑ Yes, describe_____

_____

In the past year, have you had any major life changes or stresses that you feel have impacted your overall health?

❑ No ❑ Yes, describe:_____

_____

Print all medications you are taking *(prescription and over the counter)*

Prescription Medication	Dose	Prescribed by	Date

Over the Counter Medication	Dose	Prescribed by	Date