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 (wheelchair, walker, etc.) ☐ Communication (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 ☐ Homemaker ☐ Looking ☐ Disabled ☐ Retired ☐ Student: _____

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

Employer: _____

Allergies

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

_____ _____

_____ _____

Medications

List with doses. Include contraceptives, vitamins, supplements, etc. Attach list if needed. **None**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Name: _____

Medical Conditions Check all that apply.

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer (type): _____
- ☐ Clotting Disorder
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Emphysema/COPD
- ☐ Gastroesophageal Reflux
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hypertension/High BP
- ☐ 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
- ☐ Appendectomy
- ☐ Thyroid Surgery
- ☐ Lung Surgery
- ☐ C-Section
- ☐ Eye Surgery
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Joint Surgery
- ☐ Varicose Vein Surgery
- ☐ Prostate Surgery
- ☐ Weight Reduction Surgery
- ☐ Small Intestine Surgery
- ☐ Spine Surgery
- ☐ Tubal Ligation
- ☐ Valve Replacement
- ☐ Vasectomy
- ☐ Vascular Surgery
- ☐ Cardiac Stint
- ☐ Bladder Surgery
- ☐ Bunionectomy

Have you ever had a blood transfusion: _____ If so, when: ____/____/____

Family History Check all that apply.

	Alcohol Abuse	Breast Cancer	Ovarian Cancer	Prostate Cancer	Other Cancers	Diabetes	High Cholesterol	Hypertension	Mental Illness
Mother									
Father									
Sister									
Brother									
Daughter									
Son									
Other									

Other Family History: _____

Name: _____

Habits and Activities

Do you use tobacco? Yes No In the Past

What Form? _____ How Much? _____

How long have you smoked? _____ How long since you quit? _____

Have you tried to quit? Yes No Would you like to quit? Yes No

Do you vape? Yes No Would you like to quit? Yes No

Do you drink alcohol? Yes No

How many drinks per week? _____

Do you use recreational drugs? Yes No In the Past

Explain: _____

Do you use marijuana: Recreationally Medically Currently In the Past

Do you get regular exercise? Yes No

What Form? _____ How Often? _____

List any hobbies or leisure activities: _____

_____

Immunizations

Vaccination	Approximate Date	Never
Covid-19	_____	☐
Influenza	_____	☐
Pneumonia (Pneumovax)	_____	☐
Tetanus Booster (Tdap)	_____	☐
TB Skin Test (PPD)	_____	☐
Hepatitis B	_____	☐
Hepatitis A	_____	☐
Varicella (Chicken Pox)	_____	☐
Shingles (Zostavax)	_____	☐

Name: _____

Preventative Care

Test or Procedure	Date and Result	Never
Colonoscopy	_____	☐
Bone Density Test	_____	☐
Cholesterol Test	_____	☐
PSA (Post Cancer Test	_____	☐
Pap Smear	_____	☐
Mammogram	_____	☐
Cholesteral	_____	☐
Glucose	_____	☐
STI Test	_____	☐
HIV Test	_____	☐

How often do you see a dentist? _____

List any abnormal screen test results (polyps, 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? Yes No

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

Gynecological and Obstetric History

How many times have you been pregnant? _____

Live Births: _____ Miscarriages: _____ Abortions: _____

Do you use contraception? Yes: _____ No

What was your age at first menses? _____

Menstrual Periods: ☐ Regular ☐ Irregular ☐ Menopausal

Age at Menopause: _____ Do you have symptoms (hot flashes, etc.)? _____

Any gynecological conditions or problems? Yes: _____ No

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? Yes: _____ No

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 that you usually care about or enjoyed?

Yes: _____ No

Name: _____

In the past year, have you had any major life changes or stresses that you feel have impacted your overall health? Yes: _____ No

Additional Comments or Concerns

_____

_____

_____

If you have not done so, please ask your current medical providers to forward a copy of your medical records to AR Health. For more information about transferring your medical records to AR Health, contact our office at (570) 322-8448.

We would like to have this form completed and returned before your first appointment. Please fax the form to (570) 322-8648 or email it to appointment@arhealthservices.org. If you cannot return the form and your appointment is less than two weeks away, please bring it to your first appointment. If your appointment is more than two weeks away, you may mail the form to the following address:

AR Health
500 W 3rd St
Williamsport, PA 17701
Attn: Dr. Haussmann