KELLY RICH FAMILY MEDICINE NEW PATIENT HEALTH QUESTIONNAIRE Our healthcare team wants your best!

Name: _____ Date of Birth: _____ Race: _____ Marital Status: _____

Education: _____ Occupation: _____ Religion: _____

MEDICAL AND FAMILY HISTORY – Please check if you or your blood relatives have had any of these:

	Self	Relative	Relationship to you		Self	Relative	Relationship
Anemia				Arthritis			
Asthma/Lung Disease				Cancer			
Depression/Anxiety				Diabetes			
Drug /Alcoholism				Eye Disease			
Gout				Heart Disease			
Hepatitis/Liver Disease				High Blood Pressure			
High Cholesterol				HIV/AIDS			
Kidney Disease				Migraine Headaches			
Osteoporosis				Seizure Disorder			
Skin Disease				Stomach Ulcer			
Stroke				Thyroid Disease			
Tremor				Other			

Medications/Supplements/Vitamins/Over the counter medications: **Hospitalizations/Surgeries:**

		Allergies:

Notes: -

_____

_____

_____

_____

Social History:

If you currently smoke cigarettes how many per day _____? How long have you smoked _____? Have you ever quit _____?

If you are a former smoker when did you quit _____ and how long did you smoke _____? Other tobacco _____?

Do you ever drink wine _____, beer _____ or liquor _____? How many drinks per week _____? Do you want to stop _____?

Health Maintenance:

	Date of most recent:		Date of most recent:
Mammogram and/or breast exam		Flu shot	
Pap smear and/or pelvic exam		Tetanus shot	
PSA and/or prostate exam		Eye exam	
Colonoscopy		Dental visit	
Cholesterol test		Other (STD testing/PPD/etc)	