



New patient

Wellness questionnaire

Your name: _____

Date of birth: _____

Today's date: _____

What brings you in today?

Please list all of your medical conditions and **when you were diagnosed** with these conditions:

#1. _____ #5. _____

#2. _____ #6. _____

#3. _____ #7. _____

#4. _____ #8. _____

Please list all of your medications, including ALL vitamins, herbal remedies, and holistic treatments. You may include things you take occasionally, or "as-needed". **Please also include the dose and how often you are taking them:**

#1. _____ #5. _____

#2. _____ #6. _____

#3. _____ #7. _____

#4. _____ #8. _____

Primary Pharmacy

Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy cross streets/Address _____

Please tell us about any medical problems in your family:

Mother: _____

Father: _____

Siblings: _____

Maternal grandmother: _____

Maternal Grandfather: _____

Paternal grandmother: _____

Paternal grandfather: _____

Aunts or uncles: _____

List your allergies, and **what kind of reactions** you have:

#1. _____ #3. _____

#2. _____ #4. _____

What surgeries have you had, and **when** did you have these surgeries?

#1. _____ #3. _____

#2. _____ #4. _____

Have you ever been hospitalized? If so, please say **when, where, and why**:

#1. _____

#2. _____

#3. _____

#4. _____

Do you currently see any other doctors or specialists? If so, please list their name, phone number, location, and date last seen:

#1. _____

#2. _____

#3. _____

#4. _____

Who lives with you at home? _____

What is your occupation? _____

Relationship status: ☐ Married/partner ☐ Widowed ☐ Single ☐ Divorced

Preferred sexual partner: ☐ Men ☐ Women ☐ Both ☐ Never sexually active

Currently sexually active: ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No

If so, how many times have you been pregnant? _____

Do you have any children? ☐ Yes ☐ No

If so, how many children do you have? _____

What kind of exercise do you enjoy, and how many minutes per week do you exercise?

How would you describe your diet?

Do you drink alcohol? ☐ No ☐ Yes, and if so, how many drinks per week? _____

Do you smoke?

☐ Yes

If so, how many cigarettes or cigars, or vaping products, do you use in a day:

☐ No

☐ In the past, but not any more. When did you quit? _____

Have you had the following routine vaccinations and/or tests?

Flu shot: ☐ No ☐ Yes, and if so, when? _____

COVID shot: ☐ No ☐ Yes, and if so, when? _____

Shingles shots: ☐ No ☐ Yes, and if so, when? _____

Tdap shot (tetanus/whooping cough): ☐ No ☐ Yes, and if so, when? _____

Colonoscopy: ☐ No ☐ Yes, and if so, when? _____ was it normal? _____

DEXA (bone density): ☐ No ☐ Yes, and if so, when? _____ was it normal? _____

Eye exam: ☐ No ☐ Yes, and if so, when? _____ was it normal? _____

Dental exam: ☐ No ☐ Yes, and if so, when? _____ was it normal? _____

STD testing: ☐ No ☐ Yes, and if so, when? _____ was it normal? _____

Women only:

Mammogram: ☐ No ☐ Yes, and if so, when? _____ was it normal? _____

Pap smear: ☐ No ☐ Yes, and if so, when? _____ was it normal? _____

Have you noticed any of these emotions in the past 2 weeks?

#1. Little interest in doing things:

☐ None

☐ Several days

☐ More than half the days

☐ Nearly every day

#2. Feeling down or depressed:

☐ None

☐ Several days

☐ More than half the days

☐ Nearly every day

Social Needs Patient Questionnaire

Health starts where we work, play, learn, eat, and sleep. Problems in any of these areas can affect your health. We may be able to provide assistance, so we hope you will answer the following questions. You do not have to answer any questions you do not want to. Anything you write will be kept confidential in your medical record.

Money and Resources

What is your current housing situation?

- ☐ I have housing
- ☐ I don't have housing (staying with others, in a hotel, in a shelter, living outside on street or in a park)
- ☐ I choose not to answer this question

What is the highest level of school that you have finished?

- ☐ Less than a high school degree
- ☐ High school diploma or GED
- ☐ More than high school
- ☐ I choose not to answer this question

What is your current work situation?

- ☐ Unemployed and seeking work
- ☐ Part time or temporary work
- ☐ Full time work
- ☐ Otherwise unemployed but not seeking work (student, retired, disabled, unpaid primary care giver)

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply

- ☐ Food
- ☐ Clothing
- ☐ Utilities
- ☐ Child care
- ☐ Medicine or any health care (medical, dental, mental health or vision)
- ☐ Phone
- ☐ Other - Please write in:
- ☐ I do not have problems meeting my needs
- ☐ I choose not to answer this question

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

- ☐ Yes, it has kept me from medical appointments or from getting my medications
- ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things needed for daily living
- ☐ No
- ☐ I choose not to answer this question

Social and Emotional Health

How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much

Additional Questions

Do you feel physically and emotionally safe where you currently live?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ I choose not to answer this question

In the past year, have you been afraid of your partner or ex-partner?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ I have not had a partner in the past year
- ☐ I choose not to answer this question