Pinehurst Medical Clinic
PRIMARY CARE

Primary Care New Patient Questionnaire

Demographics　　　　　　　　　　　　　　　　　MRN: ________________

Name: ____ DOB: ________________

Emergency Contact Relationship & Phone Number:

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Other Providers/Specialists involved in your care:

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Social History

Tobacco Use: ☐ Cigarettes/Cigars ☐ Snuff/Chewing Tobacco ☐ Vapor

How many packs/day? __________ How many years? ________ Previous quit date ____________

☐ Never a user

Alcohol Use: ☐ None ☐ How many drinks per day/week _________

Marijuana Use: ☐ Yes ☐ No

Other recreation drugs if applicable: ____

Marital Status: ☐ Married ☐ Single ☐ Widowed/Divorced

Children: ☐ No ☐ Yes If yes, how many? ______________

Medical History

*Please include all over the counter medication and vitamins.

Allergies/Reactions:

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Current Medications	Strength	How Often	Who Prescribes

Current and past medical issues:

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Family History

	Cancer	Lung Problems	High Blood Pressure	Diabetes	Heart Problems	Stroke	Unknown
Self							
Mother							
Father							
Maternal Grandparent(s)							
Paternal Grandparent(s)							
Maternal Great Grandparent(s)							
Paternal Great Grandparent(s)							
Sister							
Brother							
Aunt							
Uncle							

Prevention

*Please check all that apply with most recent date and performing provider.

Tetanus ____________________________

Pneumonia Vaccine __________________

Flu Vaccine _________________________

Hepatitis B Series ____________________

Prevnar _____________________________

Pap Smear ___________________________

Colonoscopy ____________________________________

Cholesterol Level Test ___________________________

Eye Exam _______________________________________

Mammogram ____________________________________

Shingles Vaccine ________________________________

Tuberculin Skin Test _____________________________

Do you exercise regularly? ☐ Yes ☐ No

How many falls have you had in the last year? ____

Do you feel safe in your home? ☐ Yes ☐ No If no, why? _____________________________________

Surgical History

*Please list all surgeries you have had with the year and performing physician.

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Review of Systems: *Please check all that apply.

Constitutional		**Skin**		**Gastrointestinal**	
Fever/Chill		Changes in moles		Hepatitis	
Weight loss		Rash/Lesions		Constipation	
Hematologic		Nipple Discharge		Diarrhea	
Bleeding Disorders		Breast abnormalities		Bloody Stools	
Endocrine		**Neurological**		Nausea/Vomiting	
Diabetes		Neurological problems		Reflux	
Thyroid Problems		Headaches		Liver Problems	
Musculoskeletal		**Genitourinary**		**Cardiovascular**	
Mobility/Joint Problems		Genital or Oral Herpes		High Blood Pressure	
Arthritis		STDs		Heart Problems	
Eyes		Kidney Problems		Blood Clots	
Glaucoma		Prostate Problems		DVT/Deep Vein Thrombosis	
Other Eye Problems		Blood in Urine		**Respiratory**	
ENT		Last Menstrual Period		Lung Problems	
Sinus Problems		Urinary Tract Infection		Asthma	
Hearing Problems		Problems Urinating		Sleep Apnea	
Dizziness		**Psychiatric**			
		Mood Swings			
		Anxiety/Depression			

If yes, please describe:

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