Pinehurst Medical Clinic
PRIMARY CARE

Primary Care New Patient Questionnaire

Name: _____ DOB: _____

Pharmacy
Preferred Pharmacy Name: *
Phone number: *
Street address (including ZIP code):

Medical History

Allergies/Reactions:

_____

Personal and Family History

	Self	Mother	Father	Grandmother (Maternal)	Grandfather (Maternal)	Grandmother (Paternal)	Grandfather (Paternal)	Sibling	Aunt	Uncle	Other
Blood Disorders											
Cancer											
Cholesterol Problem											
Diabetes Mellitus											
Glaucoma											
Heart Problems											
Hypertension											
Lung Problems											
Sleep Disorders											
Stroke											
None											
Other											

Social History

Tobacco Use: ☐ Cigarettes/Cigars ☐ Smokeless Tobacco E-Cigarettes or Vape

☐ Pipe Tobacco (including hookah) ☐ Prefer Not To Answer

☐ Never A User

How many packs/day? _____ How many years? _____ Previous quit date _____

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

Marijuana Use: ☐ Yes ☐ No

Other recreation drugs if applicable: _____

Exercise: ☐ No ☐ Yes If yes, how many times per week? _____

Marital Status: ☐ Married ☐ Single ☐ Widowed/Divorced

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

Have you had any falls in the last year? ☐ No ☐ Yes If yes, how many falls? _____

Do you feel safe at home? ☐ No ☐ Yes

If no, please provide more information:_____

Surgical History

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

_____

_____

_____

_____

Prevention

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

Colonoscopy: _____

Mammogram: _____

Eye Exam: _____

Pap Smear _____