PRIMARY CARE ASSOCIATES
MASS GENERAL WEST
NEW PATIENT QUESTIONNAIRE

Name: _____ DOB:_____ Date completed: _____

Where have you received health care previously?_____

Do you require a translator? Yes No

Do you have any hearing, vision or memory issues we should be aware of? Yes No

Explain_____

Specific health concerns to address today:_____
_____

PAST HEALTH HISTORY

In the PAST, have you had any problems with any of the following?

	Yes	No
Cancer, please specify:		
Skin Disease		
Headache/Migraine		
Stroke		
Multiple Sclerosis		
Seizure Disorder		
Traumatic Head Injury		
Allergies/Recurrent Sinusitis		
Diabetes		
Thyroid Disorder		
Asthma/Emphysema/COPD		
Other Lung Disorder		
Heart Attack or Angina		
Abnormal Heart Rhythm/Heart Valve Problems		
High Blood Pressure		
High Cholesterol		
Heartburn/Reflux/Peptic Ulcer Disease		
Hepatitis/Liver Problems		
Other Intestinal Disorders		
Back Pain/Arthritis/Joint Pain		
Osteoporosis/Multiple Fractures		
Rheumatologic Disorders (e.g. RA, Lupus)		
Kidney Stones		
Recurrent UTIs/Incontinence		
Gynecologic Disorder (e.g. Uterus, Ovary)		
Prostate Disorder		
Blood Disorders (e.g. Anemia, Blood Clots)		
Infectious Disease (e.g. HIV, TB)		
Eating Disorders		
Depression/Anxiety or Panic Attacks		

SURGICAL HISTORY

Year: _____ Procedure: _____Year: _____ Procedure: _____
Year: _____ Procedure: _____Year: _____ Procedure: _____

HOSPITALIZATIONS

Year: _____ Reason: _____Year: _____ Reason: _____
Year: _____ Reason: _____Year: _____ Reason: _____

FAMILY HISTORY

Please list medical problems for blood relatives, especially history of: HIGH BLOOD PRESSURE, HEART PROBLEMS, CANCER, BLOOD CLOTS, DIABETES, OSTEOPOROSIS, AND AUTOIMMUNE DISORDERS.

Mother _____ Maternal Grandmother _____
Father _____ Maternal Grandfather _____
Brother _____ Paternal Grandmother _____
Sister _____ Paternal Grandfather _____
Others_____

ALLERGIES

Have you ever had a life-threatening allergy reaction (i.e. anaphylaxis)? YES NO

If yes, please explain: _____

Drug Allergy:	**Reaction:**	**Food/Other Allergies:**	**Reaction:**

MEDICATIONS

Please list all prescription, nonprescription, natural products or vitamins you currently take:

Drug Name:	**Dosage:**	**Frequency:**	**How long taken:**

HABITS

Do you smoke? YES NO If yes, how many cigarettes/day? _____

Would you like to quit? YES NO

Did you smoke in the past? YES NO

If yes, how many cigarettes/day? _____ Total years smoked: _____

How often do you have a drink containing alcohol?

Never (0) Monthly or less (1) 2-4 times/month (2) 2-3 times/week (3) 4 or more times/week (4)

When you drink, how many drinks do you typically have?

1 or 2 (0) 3 or 4 (1) 5 or 6 (2) 7-9 (3) 10+ (4)

How often did you have six or more drinks on one occasion in the past year?

Never (0) Less than monthly (1) Monthly (2) Weekly (3) Daily or almost daily (4)

Do you use any non-prescribed drugs (e.g. marijuana, cocaine, heroin, pills)? YES NO

Have you ever used any of these drugs in the past? YES NO

HEALTH MAINTENANCE

Please indicate if you have received the following tests, with most recent date and result:
COLONOSCOPY: _____
MAMMOGRAM: _____
PAP: _____
BONE DENSITY: _____
PSA: _____

EYE EXAM: _____
DENTAL VISIT: _____

Please indicate if you have received the following vaccinations.

Measles/Mumps/Rubella	YES	NO	Pneumococcal	YES	NO
Hepatitis B	YES	NO	Meningococcal	YES	NO
Tetanus/Diptheria/Pertussis	YES	NO	HPV (Gardasil)	YES	NO
Chicken pox	YES	NO	Flu	YES	NO

Have you completed an advanced directive, a living will or durable power of attorney for healthcare? YES NO

Do you wear a seatbelt on a regular basis? YES NO

Do you wear sunscreen? YES NO

WOMEN ONLY

Date of last menstruation:_____ How old were you when you had your first period? _____

Do you still menstruate?

___ Yes, regularly ___ Yes, but not regularly

No, I no longer have menstrual periods because of:

___ Natural Menopause ___ Hysterectomy

Are you currently having problems with pelvic pain, irregular or heavy menses? YES NO

If yes, please explain: _____

Pregnancies _____ # Children _____ # Miscarriages _____ # Abortions _____

Have you ever had a breast biopsy? YES NO If yes, please explain: _____

Have you ever had an abnormal Pap? YES NO If yes, when: _____

SOCIAL HISTORY

Do you live alone? YES NO If no, with whom do you live: _____

Occupation: _____

On average, how many servings per day do you have of high calcium foods (e.g. 1 cup of milk, ½ cup of yogurt, 2 oz. of cheese) or a 300 mg Tums or calcium supplement? _____

Do you follow a special diet? If yes, please explain _____

How many cups of coffee do you drink a day? _____

How many times per week do you exercise?

Not at all 1-2x 3-4x 5-7x

Type of exercise/duration: _____

Have you ever been sexually active? YES NO If yes, with men, women, or both? _____

Are you currently in a sexual relationship? YES NO

Have you ever had a sexual transmitted infection? YES NO

If applicable, type of birth control you are using: _____

Do you consider religion / spirituality an important part of your life/health? YES NO

SAFETY

Do you have any concerns regarding domestic or sexual abuse?_____

MENTAL HEALTH

Over the last 2 weeks, how often have you been bothered by the following problems?

Feeling nervous, anxious or on edge:
Not at all (0) several days (1) more than half the days (2) nearly every day (3)

Not being able to stop or control worrying :
Not at all (0) several days (1) more than half the days (2) nearly every day (3)

Little interest or pleasure in doing things:
Not at all (0) several days (1) more than half the days (2) nearly every day (3)

Feeling down, depressed, or hopeless:
Not at all (0) several days (1) more than half the days (2) nearly every day (3)

Thank you for joining our practice. We welcome your feedback on this questionnaire. If you have any suggestions, please let us know.