STEWART

Family Medicine & After-Hours

New Patient Registration

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL & WILL BECOME PART OF YOUR MEDICAL RECORD.

HOW DID YOU HEAR ABOUT US?

DATE	NAME	DOB	SSN

*****WE REQUIRE AT LEAST 2 PHONE NUMBERS FOR EVERY PATIENT*****

CONTACT INFORMATION			
Home Phone		Mailing Address	
Cell Phone			
Email		DL #	

PLEASE CHECK THE APPROPRIATE BOXES	
☐ Male ☐ Female	☐ Hispanic / Latino ☐ Non-Hispanic / Non-Latino
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	☐ White ☐ Black Or African American ☐ Asian ☐ Other: ________________

EMERGENCY CONTACT	
Name	
DOB	
Phone	
Relation	
Mailing Address	

INSURANCE INFORMATION			
Primary		Secondary	
Policy Holder Name	Policy Holder DOB	Policy Holder Name	Policy Holder DOB
Patient's Employer		Employer Phone	

Do you see another health care provider for your primary healthcare needs?				
☐ YES ☐ NO	Primary Care Provider		Office Phone	

Please list any other medical providers / specialists that you see.					
Provider Name		Office		Phone	
Provider Name		Office		Phone	

Do you have an Advanced Directive, Living Will, Power of attorney, or DNR?	☐ YES ☐ NO

I have reviewed all of the information on this form and agree that it is true and accurate. I understand that it is my responsibility to notify Stewart Family Medicine of any changes that may occur to the information I have given on this form.

Patient's Signature		**Printed Name**		**Date**	

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Comprehensive New Patient Health History Questionnaire

Your answers on this form will help your healthcare provider get an accurate history of your medical concerns and conditions.
Please fill in ALL pages. It is long because it is comprehensive. We really want to know you well so we can properly care for you.
If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it.
Thank you!

DATE	NAME	DOB	SSN

Main reason for today's visit?			
Is this a work related injury?	☐ YES ☐ NO	Date of Injury?	

MEDICATIONS

Please list all prescriptions and non-prescription medications. This includes vitamins, herbs, home remedies, birth control pills, inhalers, over the counter pain pills. *Or you can provide us a list of your medications or printed record.*

☐ Check box if you do not take any prescriptions or over the counter medications.

☐ Check box if you brought a list of your medications. (Give to assistant and do not write medications below).

MEDICATION	DOSE	How many times per day?

Please list any known ALLERGIES *or* intolerance to medications.

PERSONAL MEDICAL HISTORY

Do *you* have now or have you had in the past any of the following conditions?

☐ Check box if you have no history of significant medical illnesses.

CONDITION	NOW	PAST	CONDITION	NOW	PAST	CONDITION	NOW	PAST	CONDITION	NOW	PAST	CONDITION	NOW	PAST
ADD			Carotid Artery Stenosis			Diverticulitis			High Cholesterol			Pneumonia		
Alcohol/Drug Abuse			Cataracts			Eczema			Hypothyroidism			Prostate Enlargement		
Allergies			Cerebral Palsy			Fractures			Hyperthyroidism			Pulmonary Embolus		
Anemia			Gallstones			GERD			IBS			Schizophrenia		
Anxiety			Cirrhosis of Liver			Glaucoma			Kidney Disease			Seizure Disorder		
Arrhythmia			Congestive Heart Failure			Gout			Kidney Stones			Sickle Cell		
Asthma			Colon Polyps			Migraines			Multiple Sclerosis			Sleep Apnea		
Autism			COPD			Heart Attack			Obesity			Stomach Ulcers		
Blood Clots			Coronary Artery Disease			Heart Murmur			OCD			Stroke		
Blood Transfusion			Depression			Hepatitis			Osteoarthritis			Thalassemia		
Bipolar Disorder			Type 1 Diabetes			Hernia			Osteoporosis			TIA		
Breast Lump			Type 2 Diabetes			HIV			Peripheral Neuropathy			UTI-Recurrent		
Cancer			Degenerative Disc			High Blood Pressure			Peripheral Artery Disease					

COMMENTS	

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Continued

WOMEN'S HEALTH HISTORY

Total # of Pregnancies:		Total # of Births:		If you are having periods, how often do they occur?		Every		Days
Total # of Miscarriages:		Total # of Abortions:		Age at First Period?		How long do they last?		Days
Age at Menopause?		Have you ever had an abnormal pap smear?		☐ YES ☐ NO		Explain:		

IMMUNIZATIONS

VACCINE	YEAR	VACCINE	YEAR
Tetanus		Influenza (FLU)	
Pneumonia		HPV	
HEP A		HEP B	
MMR		Meningitis	
Varicella (Chicken Pox)		Zostavax (Shingles)	

HEALTH MAINTENANCE / SCREENING

TEST	DATE	NORMAL	ABNORMAL
Lipid Panel (Cholesterol)		☐	☐
Colonoscopy		☐	☐
WOMEN ONLY			
Mammogram		☐	☐
Pap Smear		☐	☐
Bone Density Test		☐	☐

SURGICAL & PROCEDURE HISTORY

Please check off any procedure or surgeries. List any abnormal findings, details or complications under comments.

☐ Check this box if you have never had any medical procedures or surgeries.

✓	Procedure	Year	✓	Procedure	Year	✓	Procedure	Year	✓	Procedure	Year
	Abdominal Surgery			Colonoscopy			Hip Surgery			Sigmoidoscopy	
	Adenoidectomy			Coronary Bypass			Hysterectomy (Partial)			Sinus Surgery	
	Angiogram			Coronary Stent			Hysterectomy (Total)			Stress Test	
	Appendectomy			C-Section			Knee Surgery			Tonsillectomy	
	Back Surgery			Echocardiogram			LEEP			Tubal Ligation	
	Biopsy			EGD			Neck Surgery			Vasectomy	
	Breast Surgery			Gallbladder Removal			Ovary Removal				
	Cataract Surgery			Heart Surgery			Pulmonary Function				

COMMENTS	

FAMILY HISTORY

Please check off any known medical problems in your family and who is diagnosed with it.

☐ Check this box if your family history is unknown.

✓	DISEASE	RELATION	✓	DISEASE	RELATION	✓	DISEASE	RELATION
	High Blood Pressure			Alzheimer's			Hip Fracture	
	High Cholesterol			Asthma			Thyroid Disease	
	Heart Attack			Autoimmune Disease			Kidney Disease	
	Diabetes			Bleeding / Clotting Disorder			Kidney Stones	
	Cancer			COPD			Macular Degeneration	
	Osteoporosis			Genetic Disorder			Stroke	
	Depression			Glaucoma			TIA	
	Alcohol or Drug Abuse			Heart Disease			Sudden Cardiac Death	

COMMENTS	

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Continued

TOBACCO USE				
Do you currently use tobacco products?	☐ YES ☐ NO	**IF NO, SKIP TO NEXT SECTION.**		
Are you a current smoker?	☐ YES ☐ NO	**Tobacco Type** *(check all that apply)*		
How many packs per day?	☐ YES ☐ NO			
For how many years?		☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Smokeless Tobacco		
Are you ready to quit?	☐ YES ☐ NO	**Former Smoker? Quit Date:**		

ALCOHOL & DRUG USE		
How many drinks per week?		
Have you ever used recreational drugs?	☐ YES ☐ NO	Please List:
Are you currently using recreational drugs?	☐ YES ☐ NO	Please List:

DIET & EXERCISE			
Do you follow a special diet?	☐ YES ☐ NO	If so, what type?	
Do you exercise regularly?	☐ YES ☐ NO	If so, what type?	

LIST ANY MEDICAL SUPPLIERS YOU USE. (Respiratory Supplies, etc.)

For Office Use Only

Room #	Provider	Pharmacy

Height	Weight	BP	Pulse	Resp	Pulse Ox	Temp	HC	LMP	MA Initials

NOTES