SharpCare Medical Group

SHARP

Patient Name: _____

DOB: _____

NEW PATIENT/WELLNESS QUESTIONNAIRE

Disclaimer: Please fill out what you are comfortable filling out. IF YOU HAVE COMPLETED THIS FORM. IN THE PAST AND HAVE VERY FEW UPDATES, PLEASE COMPLETE ONLY THOSE SECTIONS.

☐**PLEASE CHECK THIS BOX IF YOU HAVE NO CHANGES FROM A PREVIOUS QUESTIONNAIRE.**

WT: _____ **HT:** _____ **Temp:** _____
B/P: _____ **Pulse:** _____ **O2%:** _____
BMI: _____

Nickname: _____

Your preferred method of contact: Home Phone/Cell Phone/Email: _____

Education level completed: _____ Preferred Language: _____

Occupation: _____

Preferred Pharmacy: _____ **Location:** _____

Do you have an Advanced Health Care Directive? ☐ No ☐ Yes

Reason for your visit: _____

Please check to indicate if you have ever had the following conditions:

☐ Diabetes	☐ High blood pressure	☐ Asthma	☐ Stroke
☐ Kidney disease	☐ Hepatitis	☐ Seizures	☐ Heart disease
☐ Lung disease	☐ Tuberculosis	☐ Depression/Anxiety	☐ Blood clots
☐ Thyroid disease	☐ Emphysema	☐ Alcoholism/Drug Addiction	☐ Congestive Heart Failure
☐ HIV	☐ Migraines	☐ Cancer-type: _____	☐ Glaucoma

Other, please explain: _____

Have you <u>recently</u> received care such as inpatient hospitalization, ER visits, Urgent Care visits, nursing home stays or other physicians? ☐ No ☐ Yes

HOSPITALIZATION

Please list any <u>past</u> Operations, Illnesses or injuries requiring Hospitalization's:

Surgeries/Operations	*Date*	*Hospitalizations Due to Illness or Injuries*	*Date*

MEDICATION

Please list all medications, including vitamins, herbal or natural supplements which you are currently taking.

Medication Name	*Dose*	*Times/Day*

ALLERGIES/INTOLERANCE

Allergy/Medication Allergy	*Type of Reaction*

FAMILY HISTORY

If any members of your family have had any of the following conditions, please place a checkmark in all applicable boxes.

☐ **I was adopted so I do not know my family history.**

Check all that applies:

Illness	Father	Mother	Sibling	Child	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother	Aunt	Uncle	Cousin
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Condition	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Endometrial Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sudden Death: Otherwise Healthy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other Comments:

WOMEN ONLY

Have you ever been pregnant? ☐ No ☐ Yes

Number of pregnancies? _____ Number of miscarriages? _____ Number of abortions? _____

How many children do you have living? _____

Do you have menstrual periods? ☐ No ☐ Yes

If yes, are your periods regular? _____ If no, at what age did they stop? _____

Have you had a hysterectomy? ☐ No ☐ Yes Partial? ☐ No ☐ Yes Complete ☐ No ☐ Yes

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Sexual Orientation: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other: _____

Are you sexually active? ☐ No ☐ Yes

Do you have children? ☐ No ☐ Yes

Do you use birth control? ☐ No ☐ Yes

Living Arrangement (check all that apply): ☐ Alone ☐ Roommate ☐ Spouse/Partner ☐ Children
☐ Parent(s) ☐ Sibling(s) ☐ Other: _____

PERSONAL HABITS

Please check all that apply:	Comments
☐ **History of Domestic Violence**	
☐ **Tobacco Use:** ☐ Never smoked ☐ Former smoker Year quit: ____ Number of yrs. Smoked: _____ Packs per day: ____ ☐ Vaping ☐ Currently Smoking ☐ Both Number of yrs.: ____ Number of yrs. Smoked: _____ Packs per day: ____	
☐ **Cannabis Use:** ☐ Never smoked ☐ Former smoker: Year quit: ____ ☐ Currently smoking Number of yrs. Smoked: ____	
☐ **Alcohol Use:** ☐ Never ☐ Occasional: ☐ 1-2 drinks per day ☐ 3+ per day ☐ Quit Use: Date quit: _____	
☐ **Drug Use: (check all that apply)** ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Amphetamine ☐ Other: _____ ☐ Former Date quit: _____ # of yrs.: _____	
☐ **Caffeine Use:** Type of Caffeine: _____ #oz: _____	
☐ **Exercise:** **Light** **Moderately** **Heavy** ☐ Exercise regularly (4-6 times/wk. for 20+mins) ☐ ☐ ☐ ☐ Exercise regularly (2-3 times/wk. for 20+mins) ☐ ☐ ☐ ☐ Exercise rarely	

PREVENTIVE HEALTH

Please CHECK and enter the last known DATE for all that apply on the following immunizations & Tests:

☐ Tetanus (Tdap): _____ ☐ Flu shot: _____ ☐ Hepatitis B: _____

☐ Pneumonia vaccine: _____ ☐ Shingles vaccine: _____ ☐ Chicken Pox: _____

☐ Last Pap smear/pelvic: _____ ☐ Last Colonoscopy: _____

☐ Last Mammogram: _____ ☐ Last Colon cancer screening: _____

Fall Screening: ☐ **Not Completed** ☐ **Completed** **Date:** _____

If you are 50 years of age or older, please complete the question below:

✓ **Checked all boxes that apply:**

☐ **Have you fallen in the last calendar year?**

If yes, how many times? _____

Were you injured? _____

DEPRESSION SCREENING

Over the last two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than one half the days	Nearly everyday
1. Take little interest or pleasure in doing things?	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed or hopeless?	0 ☐	1 ☐	2 ☐	3 ☐

✓ **If you checked any boxes in 1 or 2, please compete questions 3 - 9.**

3. Trouble falling or staying asleep, or sleeping too much?	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy?	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating?	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down?	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television?	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed? OR the opposite- Being so fidgety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead or of hurting yourself in some way?	0 ☐	1 ☐	2 ☐	3 ☐

OFFICE / INTERNAL USE ONLY:

Score Questions 1 & 2 Total: _____

Score Questions 3 - 9 Total: _____

Depression Screening Total Score: _____