Christian Health Service of Syracuse New Patient Questionnaire (Adult)

Name: _____ **Date of Birth:** _____

Chronic Health Issues/Medical History – Do you suffer from ?:

Health issue	Y/N		Y/N		Y/N
Diabetes		Chronic abdominal pain		Asthma	
Hypertension		Heartburn/Acid reflux		COPD/Emphysema	
Headaches		History of concussion		Chronic sinusitis	
High cholesterol		Depression		Insomnia	
History of Heart attack		OCD/Obsessive Compulsive Disorder		Other:	
Bypass surgery		Anxiety		Other:	

Surgeries

Year	Procedure performed

Family History(health issues such as Heart Disease, Hypertension, High cholesterol Diabetes, Cancer and Mental Health Problems)

Mother -_____

Father -_____

Sisters (number and any illnesses) _____

Brother (number and any illnesses) _____

Medication Allergies -

_____

_____

Medications (include over-the counter supplements too)

Name: Dose How you take it

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Immunizations **Date** **Date**

Tetanus (Tdap, Td, Dtap)_ _____ MMR

Hepatitis B Pneumonia shot (pneumovax)

Shingles vaccine (zostavax) Chickenpox vaccine

Social History

Home life (circle) - alone, with roommates, partner/spouse, other

Do you Exercise? (circle) - Yes No what type/ how much per week_____

Ever smoke Cigarettes (circle) - No Yes Packs per Day _____ Quit date _____ Planned Quit date _____

Are you employed (circle) Yes No - If Yes, what is your job? _____

Going to school? Yes No If Yes then what are you studying _____

Street Drug use? - present Yes _____ No____ past Yes_____ No____

Alcohol use? (circle) None Social Daily

Do you wear seatbelts ? (circle) Yes - Usually - Sometimes -No

Women's Health

Age when menstrual cycles began: _____

Age when menstrual cycles ended: _____

Have you ever felt unsafe in a relationship _____

Have you ever been abused as an adult or child _____

Contraception- What do you use? _____