GREENVILLE HEALTH CARE

NEW PATIENT APPLICATION QUESTIONNAIRE

DEMOGRAPHICS:	
Name:	Address:
Phone: (home) (cell)	
Insurance Provider:	Date of Birth:
Who has been your primary care provider?	
Please list any other health care providers you see regularly and their specialty:	

MEDICATIONS: Please list (or show us your own printed record) of all prescriptions and non-prescription medications you are MOGRAPHICS: includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter medications, etc.

Medication	Dose	How many times per day

ALLERGIES or intolerance to medications?	
Medication/Food/Misc	Reaction

IMMUNIZATIONS: Enter year (if known) of any vaccinations you have had.	
Tetanus (Td)	Tetanus (Tdap)
Varicella (shot or illness)	Pneumovax (pneumonia)
Influenza (flu shot)	Hepatitis A
Hepatitis B	MMI
Meningitis	Zostavax/Shingrix (shingles)
HPV	COVID
HEALTH MAINTENANCE SCREENING TESTS: Enter year (if known)	
Lipid (cholesterol)	Sigmoidoscopy or colonoscopy
PSA (blood prostate screening)	Mammogram
PAP Smear	Bone Density Testing

PERSONAL MEDICAL HISTORY: Do you haor have you had in the past any of the following?			
Condition	**Yes**	**No**	**Comments**
Abnormal PAP smear			
Alcohol/Drug Abuse			
Allergies (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid/Osteoarthritis)			
Asthma			
Bladder/Kidney Problems			
Blood Clot (leg/lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer Location:			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Dementia			
Diabetes (adult or childhood onset)			
Diverticulosis			
Emphysema (COPD)			
Endometriosis			
Fibroids (Uterine)			
Fractures (broken bones)			
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Gout			
Heart Attack			
Hepatitis Type: A B C Other			
High Blood Pressure			
High Cholesterol			
Irritable Bowel Syndrome			
Kidney Disease/Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate Enlargement or Nodules			
Seizures/Epilepsy			
Skin Issues Eczema/Psoriasis/Abnormal Moles			
Sleep Apnea			
Stomach Ulcers			
Stroke			
Thyroid Disease or Nodules			
Other:			
Other:			
Other:			
Other:			

SURGICAL AND PROCEDURAL HISTORY: Please check off any procedures/e

Surgical Procedure	Year	Comments
Abdominal Surgery		
Angiogram (heart)		
Angiogram (vascular)		
Appendectomy		
Back Surgery		
Biopsy		
Breast Surgery		
Cataract Surgery		
Colonoscopy		
Coronary Bypass		
Coronary Stent		
Cesarean Section		
Echocardiogram (heart)		
EGD (stomach endoscopy)		
Gallbladder Removal		
Heart Surgery		
Hip Surgery		
Hysterectomy Partial/Complete/Total		
Joint Replacement		
Knee Surgery		
LEEP (cervix surgery)		
Neck Surgery		
Pulmonary Function Test		
Sigmoidoscopy		
Sinus Surgery		
Stress Test (cardiac)		
Tonsillectomy		
Tubal Ligation		
Vasectomy		
Other:		
Other:		
Other:		
Other:		
Other:		

HEALTH ISSUES:

Tobacco Use: Yes No If yes, please complete the following:
What do you smoke (Please circle one): Cigarettes Cigars Pipe Other:_____
How long have you been smoking: _____ years
How much do you smoke per day: _____ packs or each
Calculated pack history: _____

Alcohol Use: Yes No If yes, please complete the following:
How much do you drink?
Beer Number per week: _____ Bottles/Cans
Wine Number per week: _____ Glass/Bottles
Liquor Number per week: _____ Drinks/Bottles

What do you drink?
Beer Number per week: _____ Bottles/Cans
Wine Number per week: _____ Glass/Bottles
Liquor Number per week: _____ Drinks/Bottles

Drug Use:
Have you **ever** used illicit or legal drugs recreationally? Yes No Current use? Yes No
Which ones?: _____

HEALTH AND SAFETY: (Please circle one)
Does your home have working smoke detector? Yes No
Does your home have working carbon monoxide detector if gas is in the home? Yes No N/A
Do you have guns in your home? Yes No If yes, are they locked up/secured? Yes No
Have you or any family members ever been hurt, insulted, threatened or screamed at? Yes No
Do you wear a seat belt when in a vehicle? Yes No
Do you wear a helmet or protective gear when appropriate? Yes No
Do you exercise regularly? Yes No
Do you follow a special diet? Yes No Please describe if yes:
SEXUAL HISTORY:
Are you sexually active? Yes No
Sexual partners are/have been/may be in future: Female Male Both
Birth control method/sexually transmitted disease prevent: (Please circle all that apply) None Barrier Method Pill IUD Patch Ring Diaphragm Tubal Ligation Vasectomy Other: (specify)
WOMEN'S HEALTH:
Total # of pregnancies: Total # of births: # of miscarriages: # of abortions:
Age at the beginning or menstruation:
How often do periods occur? Every _____ days How long do they last? _____ days
How heavy are your periods? Heavy with clots Moderate Light Cramping? Yes No
Age at end of periods (menopause/hysterectomy)
Do you have concerns about your periods or menopause you'd like to discuss? Yes No
SOCIOECONOMIC:
Marital Status: (Please circle one) Single Partner Married Divorced Widow(er)
Education: High school or GED Trade school College Graduate school Other
MEDICAL FORMS:
Do you have Advance Directive for Health Care (ADHC)? Yes No
Do you have Durable Power of Attorney for Healthcare Decisions? Yes No
Do you have a Living Will? Yes No
Do you know about these or have the forms but have not completed them? Yes No
Don't know what these are? Yes No

Family Member	Maternal grandmother	Maternal grandfather	Paternal grandmother	Paternal grandfather	Mother	Father	Brother	Brother	Brother	Sister	Sister	Sister	Son	Son	Daughter	Daughter	Other
Alive(A)/ Deceased (D) (Please circle one)	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased	Alive Deceased
CONDITION:																	
Adopted/Unknown family history																	
No significant history																	
Alcoholism/Drug Abuse																	
Alzheimer's																	
Asthma																	
Autoimmune Disease																	
Bleeding or Clotting Disorder																	
Cancer, Breast																	
Cancer, Colon																	
Cancer, Lung																	
Cancer, Ovarian																	
Cancer, Other																	
Cancer, Prostate																	
Colon Polyp																	
Depression																	
Diabetes – Insulin dependent																	
Diabetes Type II Adult onset																	
Emphysema																	
Genetic Disorder																	
Glaucoma																	
Heart Attack, Angina, Coronary Heart Disease																	
Heart Disease, Congestive Heart Failure																	
Heart Disease, Other																	
Hepatitis B or C																	
Hip Fracture																	
Hyperlipidemia																	
Hypertension																	
Hyperthyroidism																	
Hypothyroidism																	
Kidney Disease																	
Kidney Stone																	
Macular Degeneration																	
Osteoporosis																	
Stroke																	
Sudden Cardiac Death																	
Thyroid Disease																	
Other																	
Other																	
Other																	
Other																	
Other																	