Boulder Community Health
PHYSICIAN CLINICS

New Patient Questionnaire/Annual Exam Questionnaire

Name:

Reason for Visit: DOB:

Other Current Doctors:

PCP: Today's Date:

PAST MEDICAL HISTORY

Abdominal Pain	☐ Yes	Drug Abuse	☐ Yes	Irritable Bowel Syndrom	☐ Yes
Abortion	☐ Yes	Eating Disorder	☐ Yes	Liver Disease	☐ Yes
AIDS	☐ Yes	Elevated PSA	☐ Yes	Migraine	☐ Yes
Alcoholism	☐ Yes	Emphysema	☐ Yes	Mononucleosis	☐ Yes
Anemia	☐ Yes	Epilepsy	☐ Yes	Osteopenia	☐ Yes
Anorexia	☐ Yes			Osteoporosis	☐ Yes
Angina	☐ Yes			Ovarian Cancer	☐ Yes
Appendicitis	☐ Yes	Gastric Ulcer	☐ Yes		
Arthritis	☐ Yes	GERD/Acid Reflux	☐ Yes		
Asthma	☐ Yes	Glaucoma	☐ Yes		
Breast Cancer	☐ Yes	Goiter	☐ Yes		
Blood Clots/DVT/PE	☐ Yes	Gout	☐ Yes	Prostate Cancer	☐ Yes
Bulimia	☐ Yes			Pneumonia	☐ Yes
Cancer	☐ Yes	Hyperthyrodisim	☐ Yes	Polio	☐ Yes
Cataract	☐ Yes	Heart Disease	☐ Yes	Rectal Bleeding	☐ Yes
Chest Pain	☐ Yes	Hemorrhagic Condition	☐ Yes	Shortness of Breath	☐ Yes
Chronic Kidney Disease	☐ Yes	Hepatitis	☐ Yes	Skin Cancer	☐ Yes
Chronic Pain	☐ Yes	Hernia	☐ Yes	Stroke/TIA	☐ Yes
Colon Disorder/Polyps	☐ Yes	Herpes Simplex	☐ Yes	Transfusions	☐ Yes
Diabetes Type I	☐ Yes	HIV	☐ Yes	Tuberculous Infection	☐ Yes
Diabetes Type II	☐ Yes	Hypercholesterolemia	☐ Yes	Other	☐ Yes
Disorder of Thyroid	☐ Yes	Hypertension	☐ Yes	Other	☐ Yes
Depression/Anxiety	☐ Yes			Other	☐ Yes

Vaginal Infections - History of : □ Yeast □ Trichomonas □ Chlamydia □ Herpes □ Gonorrhea

HOSPITAL ADMISSIONS / SURGERIES (excluding pregnancy)

Year	Description	Year	Description

CURRENT MEDICATION

Medication	Frequency of Dose	Medication	Frequency of Dose

Contraceptive History Current Method _____ Past methods_____

DRUG ALLERGIES	REACTION	FOOD/OTHER ALLERGIES	REACTION

FAMILY HISTORY Have any of your close relatives had any of the following conditions?

Condition:	Relation to you	Maternal/Paternal	Age	Condition:	Relation to you	Maternal/Paternal	Age
☐ Breast Cancer				☐ Kidney Disease			
☐ Blood Disorder				☐ Lung Disease			
☐ Colon Cancer				☐ Melanoma			
☐ Cancer				☐ Ovarian Cancer			
☐ Diabetes				☐ Prostate Cancer			
☐ Heart Disease/Stroke				☐ Skin Cancer			
☐ High Blood Pressure				☐ Other			

SOCIAL HISTORY

Feels Safe at home ☐ Yes ☐ No Vision Impaired ☐ Yes ☐ No Primary Language

Seatbelts used ☐ Yes ☐ No HIPAA Privacy ☐ Yes ☐ No Speak up brochure ☐ Yes ☐ No

Hearing aids ☐ Yes ☐ No Out of the country in the last year ☐ Yes ☐ No

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐

Tobacco: ☐ Never ☐ Former Quit Date _____ ☐ Current #/type/amount per day _____

Alcohol ☐ Yes ☐ No ____Drinks/Week Street drugs ☐ Yes ☐ No

Caffeine: Tea/Coffee _____ cups/day Colas _____cans/day

Exercise: ☐ Yes ☐ No If yes activity: _____ How often per week: _____

Sexually Active: ☐ Yes ☐ No ☐ Wish to Discuss

Signature:_____

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