Milford Regional Physician Group

The Benchmark for Quality Care

NEW PATIENT QUESTIONNAIRE

NAME:	**DATE:**
ADDRESS:	**BIRTHDATE:**
	AGE:
	HOME PHONE:
	CELL PHONE:
NAME YOU LIKE TO BE CALLED:	**EMAIL:**
MAY WE LEAVE MESSAGES ON YOUR ANSWERING MACHINE? YES or NO	
EDUCATION LEVEL: □ **HIGH SCHOOL GRADE COMPLETED** □ **COLLEGE DEGREE**	
OCCUPATION:	**WORK PHONE:**
EMPLOYER:	
MARITAL STATUS: ☐ **MARRIED** ☐ **SINGLE** ☐ **LIVING WITH PARTNER** ☐ **WIDOWED** ☐ **DIVORCED**	
NAME OF SPOUSE/PARTNER:	
HIS/HER OCCUPATION:	
MAY WE SPEAK WITH ANYONE ABOUT YOUR HEALTHCARE? YES or NO NAME:	
EMERGENCY CONTACT:	**PHONE:**
RELATIONSHIP:	**POLICY #**
NAME OF INSURANCE:	
PRIMARY CARE PHYSICIAN:	
WHO REFERRED YOU TO US?	
WHY HAVE YOU COME TO THE OFFICE TODAY?	

SOCIAL AND HEALTH HISTORY

	YES	NO	
HAVE YOU EVER SMOKED?			**____ PACKS/DAY x ____ YEARS ☐ QUIT DATE:**
DO YOU SMOKE NOW?			**____ PACKS/DAY x ____ YEARS**
DO YOU USE E - CIGARETTES?			
DO YOU SMOKE MARIJUANA?			**DO YOU HAVE A PRESCRIPTION? _____**
DO YOU DRINK ALCOHOL?			**_____ DRINKS/WEEK**
DO YOU USE DRUGS?			**WHAT TYPE? _____**
DO YOU WEAR A SEATBELT?			
DO YOU WEAR SUNSCREEN?			
DO YOU DRINK CAFFEINE?			**_____ DRINKS PER DAY**
DO YOU EXERCISE?			**_____ DAYS PER WEEK**
HAVE YOU BEEN HURT OR THREATENED BY ANYONE?			

GYNECOLOGIC HISTORY

FIRST DAY OF LAST PERIOD:	**AGE PERIODS BEGAN:**
LENGTH OF PERIODS (# DAYS BLEEDING):	**NUMBER OF DAYS BETWEEN PERIODS:**
HAVE YOU EVER HAD SEX: ☐ YES ☐ NO	**ARE YOU SEXUALLY ACTIVE? ☐ YES ☐ NO**
SEXUAL PARTNERS ARE: ☐ MEN ☐ WOMEN ☐ BOTH	**# SEXUAL PARTNERS LIFETIME:**
PRESENT METHOD OF BIRTH CONTROL:	**CONDOMS: ☐ YES ☐ NO**
WHEN WAS YOUR LAST PAP TEST?	**RESULT:**
HAVE YOU EVER HAD AN ABNORMAL PAP TEST? ☐ YES ☐ NO	
DO YOU DO BREAST SELF EXAMINATIONS? ☐ YES ☐ NO	
HAVE YOU HAD A COLONOSCOPY? ☐ YES ☐ NO	
WHEN WAS YOUR LAST MAMMOGRAM?	**RESULT:**

OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER
PREGNANCIES		**ABORTIONS**		**MISCARRIAGES**	
PREMATURE BIRTHS		**LIVE BIRTHS**		**LIVING CHILDREN**	

	DATE	WEEKS PREGNANT	BABY'S SEX	BABY'S WEIGHT	TYPE OF DELIVERY (VAGINAL/C-SECTION)	LOCATION/NAME OF DOCTOR OR MIDWIFE
1.						
2.						
3.						
4.						
5.						

WERE THERE ANY COMPLICATIONS WITH ANY OF YOUR PREGNANCIES? ☐ NO ☐ YES IF YES, PLEASE DESCRIBE:

CURRENT MEDICATIONS
(INCLUDING HORMONES, VITAMINS, HERBS, AND OTC MEDS)

DRUG NAME	DOSAGE	WHO PRESCRIBED

ALLERGIES

MEDICATION ALLERGIES	
OTHER ALLERGIES	

PAST MEDICAL HISTORY
(Check for Yes, Please Explain)

PERSONAL HISTORY		
DEPRESSION OR ANXIETY	☐	
CANCER	☐	
DIABETES	☐	
HIGH BLOOD PRESSURE	☐	
MIGRAINE HEADACHE	☐	
SEIZURES/EPILEPSY	☐	
STROKE/BLOOD CLOTS	☐	
HEART ATTACK/HEART DISEASE	☐	
ASTHMA/RESPIRATORY DISEASE	☐	
BOWEL/GASTROINTESTINAL PROBLEMS	☐	
GALLBLADDER/LIVER DISEASE	☐	
KIDNEY INFECTION/STONE	☐	
ANEMIC/ BLOOD TRANSFUSIONS	☐	
OSTEOPOROSIS	☐	
THYROID DISEASE	☐	
AUTOIMMUNE DISORDERS	☐	
SEXUALLY TRANSMITTED INFECTION	☐	
GENITAL HERPES	☐	
EATING DISORDERS	☐	
OTHER (PLEASE EXPLAIN)	☐	

DO YOU HAVE ANY OF THE FOLLOWING?

☐ WT GAIN	☐ WT LOSS	☐ FEVER	☐ HEADACHE	☐ FATIGUE
☐ DEPRESSION	☐ ANXIETY	☐ CRYING	☐ HAIR LOSS	☐ HEAT OR COLD INTOLERANCE
☐ SWELLING	☐ CHEST PAIN	☐ PALPITATIONS	☐ BLEEDING/ BRUISING	☐ SHORTNESS OF BREATH
☐ CONSTIPATION	☐ DIARRHEA	☐ BLOODY STOOL	☐ NAUSEA/ VOMITING	☐ SWOLLEN LYMPH NODES
☐ IRREG PERIODS	☐ PAINFUL PERIODS	☐ ABNORMAL VAGINAL BLEEDING	☐ PMS	☐ HOT FLASHES
☐ PAINFUL INTERCOURSE	☐ VAGINAL ODOR	☐ VAGINAL SORES	☐ ABNORMAL DISCHARGE	☐ RASH
☐ PAINFUL URINATION	☐ FREQUENT URINATION	☐ LEAKAGE OF URINE	☐ BLOOD IN URINE	☐ WORRISOME MOLES
☐ MUSCLE WEAKNESS	☐ JOINT PAIN	☐ BREAST PAIN	☐ BREAST LUMP	☐ NIPPLE DISCHARGE

SURGERIES OR HOSPITALIZATIONS

REASON	DATE	HOSPITAL

FAMILY MEDICAL HISTORY

MOTHER:	**☐ LIVING □ DECEASED, CAUSE: AGE:**
FATHER:	**☐ LIVING □ DECEASED, CAUSE: AGE:**
SISTERS:	**HOW MANY? _____ AGES:**
BROTHERS:	**HOW MANY? _____ AGES:**

ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET	
BREAST CANCER	☐		
OVARIAN CANCER	☐		
UTERINE CANCER	☐		
COLON CANCER	☐		
OTHER CANCER	☐		
DIABETES	☐		
STROKE/BLOOD CLOTS	☐		
HEART DISEASE	☐		
HIGH BLOOD PRESSURE	☐		
HIGH CHOLESTEROL	☐		
BIRTH DEFECTS	☐		
DRUG/ALCOHOL ABUSE	☐		
MENTAL ILLNESS/DEPRESSION	☐		
OTHER	☐		

THANK YOU FOR COMPLETING THIS FORM!

WE HOPE YOU HAVE A SUCCESSFUL FIRST VISIT WITH US!