OPEN DOOR

New Patient History Questionnaire

Name: _____ DOB: _____ Today's Date: _____

General Health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Past Medical Illnesses:

- ❑ accidents, broken bones, other serious injury
- ❑ anemia (low blood count) or bleeding problems
- ❑ lung problems: pneumonia, emphysema, etc.
- ❑ heart problems, high blood pressure, etc.
- ❑ gland problems: diabetes, thyroid trouble, etc.
- ❑ gastrointestinal problems: ulcers, diarrhea, etc.
- ❑ allergies (asthma, eczema, hayfever)
- ❑ cancer
- ❑ liver or kidney problems
- ❑ pain: low back pain, headaches, etc.
- ❑ skin disease
- ❑ tuberculosis (or positive skin test)

Other: (And details on items checked above) _____

_____

When was your last:

Tetanus shot? _____ Pneumonia Shot _____ Flu Shot? _____ Mammogram? _____

Pap Smear? _____ Have you ever had an abnormal pap smear? ❑ No ❑ Yes If yes, when? _____

Past Surgeries: _____

_____

Current Medications: (include over-the-counter medicines, sleeping pills, aspirin, laxatives, vitamins, etc.)

_____

_____

Allergies: Do you have drug allergies? ❑ No ❑ Yes → to what? _____

Do you have a living will or advance directive? ❑ No ❑ Yes

Family History: Are you adopted? ..... ❑ No ❑ Yes

Has anyone in your family had trouble with the following:
(include mother(M), father (F), sister (S), brother (B), grandmother (GM), and grandfather (GF).)

❑ Alcoholism or ❑ drug abuse	Yes	No	Unsure	Who?
Blood clots in legs or chest				
❑ Depression or ❑ other mental illness				
Diabetes				
Cancer				What organs? What age?
Heart attack				What age?
High blood pressure				
High cholesterol				
Stroke				
Tuberculosis				
Thyroid disease				

Sexual History:

Are you having sex? ❑ No ❑ Yes When was the last time you had sex? _____ With whom? ❑ Men ❑ Women ❑ Both

Are you trying to get pregnant? ❑ No ❑ Yes If no, what kind of birth control do you use? _____

Pregnancy: Have you ever been pregnant? ❑ No ❑ Yes **If yes**, please indicate the number of:

Living Children: _____ Abortions: _____ Miscarriages: _____ Live births: _____ Stillbirths: _____ Caesarians: _____

Have you had problems with prior pregnancies? _____

Habits (please indicate if you have ever used and how much you use now)

Caffeine: Coffee, tea, soda ..... ☐ No ☐ Yes

How many cups per day of each? _____

Tobacco: Do you smoke cigarettes now? ..... ☐ No ☐ Yes

In the past? ☐ No ☐ Yes *If yes, when did you quit?* _____

Do you use chewing tobacco, snuff, cigars, a pipe, or other forms of tobacco? ..... ☐ No ☐ Yes

Alcohol: Do you drink alcohol (beer, wine, liquor, mixed drinks, etc.)? ..... ☐ No ☐ Yes

If you drink, have you ever felt the need to cut down on drinking? ..... ☐ No ☐ Yes

How much do you drink each week? _____

Drugs: Do you use any recreational drugs? ..... ☐ No ☐ Yes

If yes, which? ☐ marijuana ☐ crack/cocaine ☐ crank/methamphetamines ☐ heroin ☐ downers ☐ other

Have you ever used drugs through a needle? ..... ☐ No ☐ Yes

Would you like help quitting: ☐ cigarettes ☐ alcohol ☐ drugs

Diet: Do you have enough money for food? ..... ☐ No ☐ Yes

Would you like instructions on healthy eating? ..... ☐ No ☐ Yes

Do you have a healthy diet? ..... ☐ No ☐ Yes

Exercise: Do you exercise ☐ less than once a week? ☐ 1-3 times per week? ☐ more than 3 times per week?

What kind of exercise? _____

Education: Completed ☐ grade school ☐ high school ☐ trade school ☐ college ☐ other: _____

Occupation: _____ Currently ☐ employed or ☐ unemployed? (last worked _____)

Living Situation: Are you now or have you recently been homeless? ☐ No ☐ Yes Do you live alone? ☐ No ☐ Yes

Whom do you live with? (Please list names and relationships with you, e.g. husband, child, parent, girlfriend, roommate, etc.)

_____

Safety:

Are there any weapons in your house? ..... ☐ No ☐ Yes

Do you feel stress or depression are a problem in your life? ..... ☐ No ☐ Yes

Do you fear anyone you are in a relationship with? ..... ☐ No ☐ Yes

Others involved in your healthcare: Do you see other health care providers (such as a therapist, other physicians, chiropractors, acupuncturists, herbalists, etc.) on a regular basis? ..... ☐ No ☐ Yes

If yes, who do you see?

Name	**Profession**
_____	_____
_____	_____
_____	_____

Are there any other issues you want to discuss with your provider? _____

_____

_____

_____