**Rush Primary Care in Oak Park**

**Patient Questionnaire—NEW PATIENT**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_

***This patient questionnaire is used to help your physician collect important information about your medical history.  Upon entry of this information into your electronic medical record, this document will be shredded.***

What issues would you like to discuss with the doctor today?

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Other than the concerns mentioned above, list your ongoing medical problems?

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When was your last complete physical exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Have you ever undergone **Surgery**? (if yes, please list with approximate dates) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Other than for surgery, have you been **Hospitalized**? (if yes, please list with approx. dates)

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Are you taking any **prescription medications**?

If yes, please list names, dosage and frequency:

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Do you have **allergies** to any medications?

If yes, please list:

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Are you taking any **over-the-counter medications**, vitamins, herbal medicines, or

nutritional supplements? (if yes, please list)

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Do you see any other Doctors?

If yes, please list and give condition for which they treat you?

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**Health Habits**



Do you smoke cigarettes or cigars?

If yes: How many do you smoke in a typical day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For how many years have you smoked? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



If you do not currently smoke, did you ever smoke?

If yes: When did you quit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many did you smoke in a typical day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For how many years did you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol?

 If yes, how many drinks per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever felt you should cut down on your drinking?

Have people annoyed you by criticizing your drinking?

Have you ever felt bad or guilty about your drinking?



Have you ever had a drink first thing in the morning to steady your nerves or

to get rid of a hangover (eye-opener)?



Do you use any Drugs?

Have you ever used intravenous Drugs? 



Do you exercise?

If yes, please describe type and frequency of exercise. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Depression Screening (PHQ-4)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **In the last 2 weeks, have you felt?** | **Not at all** | **Several Days** | **More than ½ days** | **Nearly every day** |
| Nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| Not able to stop or control worrying | 0 | 1 | 2 | 3 |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Down, depressed or hopeless | 0 | 1 | 2 | 3 |

(for office coding, T= \_\_\_\_\_\_\_)

**Vaccination History**

When was your last tetanus booster? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you get a flu shot last fall/winter?

Have you been vaccinated for pertussis (whooping cough)?

Have you been given the pneumococcal (pneumonia) vaccine?

If over age 60, were you given the Zoster (shingles) vaccine?

If you are under age 25, were you given the HPV vaccine?

In the past 10 years, were you given any other vaccinations?

If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical History**

|  |  |  |
| --- | --- | --- |
| Relative | Age (or circle age at death) | Medical Conditions |
| Natural Father |  |  |
| Natural Mother |  |  |
| Siblings |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Children |  |  |
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Is there any other pertinent family history? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Screening History *(women)***

When was your last pap smear?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ever had an abnormal Pap smear? If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you ever test positive for HPV?

Over age 40: when was your last mammogram?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Have you ever had an abnormal mammogram?

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If post-menopause, have you ever had a bone density test?

 If yes, was it normal?

**Screening History *(men)***

If over age 50, or 40 with a family history of prostate cancer:

When was your most recent prostate exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your most recent PSA blood test? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Screening History (ALL)**

When was your last eye exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Was it normal?

If over the age of 50, when was your most recent colonoscopy? \_\_\_\_\_\_\_\_\_\_\_\_

Was it normal? 

Is there anything not asked on this questionnaire that you would like to speak about on your visit?

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