

PATIENT PRELOAD QUESTIONNAIRE

In order to best care for you, please fill out the following information. This form only needs to be completed once so we can enter the information in our new electronic medical record. If you have already completed this form you do not need to fill it out again.

If you are unsure of a question or do not feel well enough to complete this form you may leave it blank and ask for assistance from the medical assistant when you are called back. Thank you.

Date: _____

Name: _____ D.O.B: _____

Name of Physician/Provider you are seeing today: _____

Medications

Are you currently taking any medications? No Yes, please list medication and dosage if known:

Preferred Pharmacy: _____

Pharmacy Address: _____

Pharmacy Tel. #: _____ Pharmacy Fax #: _____

Medication	Dose	Directions	Date Started

Allergies

Are you allergic to anything? No Yes, please list drug(s) and reaction(s):

Allergy	Reaction (e.g. hives, rash itching)	Onset (Date your allergy started)

Immunizations (approximate dates are fine)

Date of your last flu shot? _____ None
 Date of your last pneumonia shot? _____ None
 Date of your last tetanus shot? _____ None

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Chronic Illness:

Do you have any current chronic illnesses such as: Diabetes, Hypertension, Heart Disease, Asthma, etc? No
 Yes, please list: _____

Past Medical History

Have you had any prior serious illness or surgeries? No Yes, please list including dates if known:

Family History (possible genetic illnesses)

Has anyone in your immediate family had any major illnesses, such as heart disease, cancer, diabetes, etc?
 No Yes, please list which family member and illness?

Family Member(s)	Diagnosis	Yes	No	Age
	Alive & Well	€	€	
	Add/ADHD	€	€	
	Alcoholism	€	€	
	Allergies	€	€	
	Alzheimer's disease	€	€	
	Asthma	€	€	
	Blood disease	€	€	
	CAD	€	€	
	CAD Premature	€	€	
	Cancer	€	€	
	CVA	€	€	
	Depression	€	€	
	Developmental Delay	€	€	
	Diabetes	€	€	
	Eczema	€	€	

Family Member(s)	Diagnosis	Yes	No	Age
	Hearing deficiency	€	€	
	Hyperlipidemia (High Cholesterol)	€	€	
	Hypertension	€	€	
	Irritable bowel disease	€	€	
	Learning disability	€	€	
	Mental illness	€	€	
	Migraines	€	€	
	Obesity	€	€	
	Osteoporosis	€	€	
	PVD	€	€	
	Renal Disease	€	€	
	Seizure disorder	€	€	
	other	€	€	
	other	€	€	
	other	€	€	

Additional Family History:

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Social History

Occupation: _____
Employer: _____

Retired

Are there any occupational hazards at your place of employment such as: asbestos, chemicals, excessive noise, potentially toxic fumes? No Yes, please list:

Do you smoke? No Yes, please list quantity:

Do you drink alcohol? No Yes, please list quantity:

Do you drink caffeine? No Yes, please list quantity:

Sources: coffee tea soda tablets

Do you use any illicit drugs? No Yes, If Yes, please list type: _____

Health Maintenance

When was the date of your last physical? _____ None

Adults age 35 and older:

When was your last cholesterol lab test? _____ None

Adult women only:

When was your last mammogram? _____ None

When was your last pap smear? _____ None

Adult men over age 50 only:

When was the date of your last prostate exam? _____ None

Adults over age 50 only:

When was your last colonoscopy? _____ None

Adults over age 65 only:

When was your last DEXA scan (Osteoporosis screening)? _____ None

Medical Record Use Only: Abstracted by
