ARKTOS
DIRECT CARE

Phone: 970-310-0753
Fax: 970-922-3550

NEW PATIENT QUESTIONNAIRE

Name: _____ **Date**: _____

DOB: _____ **Address**: _____

Gender: _____ _____

Phone: _____ **Cell**: _____

Email: _____

What would you like the doctor to call you? _____

Please list how you would like to be contacted for test results: ☐ **Home** ☐ **Cell** ☐ **Portal** ☐ **Email**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widow** **Spouse's Name**:_____

Please list your main reason for making an appointment:

_____

_____

Allergies/Drug Reactions (Please list drug and the reaction):

_____

_____

_____

_____

Please list current medical problems: (List conditions you are currently being treated for)

_____

_____

_____

_____

Past Medical History: (Please list past major medical problems, hospitalizations)

_____

_____

_____

_____

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Past Surgical History: (*Please list all surgeries and dates*)

Who lives with you, in your home? (*Spouse, children, in-laws, significant others, ect…*)

Occupation:

What are your hobbies?

Birthplace:

Education:

What are your health goals?

Do you get regular exercise? (*If yes, describe*)

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Smoking History

☐ **Never smoked**

☐ **Previous smoker (age started) _____ (age stopped) _____**

On average, how many packs a day? _____

☐ **Current smoker (age started) _____**

On average, how many packs a day? _____

Do you drink wine, beer, or other alcoholic beverages? ☐ **Yes** ☐ **No** ☐ **Socially**

If yes, how many times in the last year have your consumed 4 or more drinks on one occasion? _____

Have you ever had a drinking problem? ☐ **Yes** ☐ **No**

How many cups of coffee or caffeinated beverages do you consume daily? _____

Do you use: marijuana, cocaine, or any other street drugs/prescriptions not prescribed for you?

☐ **Yes** ☐ **No** (*Leave blank if you would prefer to discuss this with the doctor*)

Family History

Please be sure to include: cancer, diabetes, high blood pressure, strokes, tuberculosis and other important illnesses

	Age if Living	Age at Death	Health problems/Cause of death
Mother			
Father			
Brothers/Sisters:			
Children:			

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*Please list all medications you are taking, including over the counter medications, vitamins, herbs, and other treatments. Include the name of the Dr. who prescribed it and WHY you are taking it. If you aren't sure on why you're taking the medication, please indicate by writing, "Don't know".

*Please remember to update your medication list when your doctor stops, changes or updates your medications. Please bring your medication list with you to doctors, ER, walk-in clinic visits, nursing home, home health visits and to the hospital. *If you are unable to bring a list with you, please bring your bottles.*

Medication Chart				
Medication	**Prescribed by**	**Dose**	**Frequency**	**Purpose**

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Past Medical History:

Please check whether you have ever had the following:

	Yes	No		Yes	No
Hypertension			Pancreatitis		
Diabetes			Kidney Problems		
Cancer			Abnormal Pap Smear		
Heart Murmur			High PSA (men only)		
Heart Problems			Seizures		
Asthma			Depression/Anxiety		
Emphysema/COPD			Stroke		
Positive skin test for TB			Blood Problems		
Tuberculosis			Thyroid Problems		
Blood Clots			Arthritis		
Asbestos exposure			Radiation treatments to head/neck		
Ulcers			STDs		
Colon Polyps			HIV infection		
Gallbladder Problems			**Other** (**List**):		
Hepatitis/Jaundice					
Liver Problems					

VACCINATIONS	Yes	No	TESTS	Yes	No
Tetanus			Stool cards for colon cancer testing		
Influenza (Flu Shot)			Colonoscopy		
Influenza (H1N1)			Sigmoidoscopy		
Pneumonia			Bone density		
Hepatitis A			Mammogram		
Hepatitis B			Pap Smear (Women Only)		
Shingles			PSA (Men Only)		
Others:			Exam by eye doctor		