APPLEDORE FAMILY MEDICINE
NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Date _______________ Name____ DOB____________________

Please List your Medical History:

____
____
____
____
____
____
____

Please List your Surgical History:

____
____
____
____
____
____
____

List all Providers you have seen:

____
____
____
____
____
____
____

List all your current medications/vitamins/supplements:

____
____
____
____
____
____

List all **ALLERGIES**/intolerances that you have to medications **AND** the reaction you have:

____
____
____
____
____

FAMILY HISTORY

Family Member	Living or Deceased	Age/ Age at time of death	Diabetes	High Blood Pressure	Breast Cancer	Coronary Artery Disease	Lung Cancer	Colon Cancer	Heart Attack	High Cholesterol	Asthma	Other
Mother												
Father												
Brother												
Sister												
Son												
Daughter												

Other Pertinent Family History:____

Patient (Guardian) Signature:____Date ________________

Physician Signature:____Date ________________

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SOCIAL HISTORY

What is your gender identity?
☐ Male ☐ Female ☐ Transgender man ☐ Transgender woman

☐ Genderqueer / Gender nonconforming ☐ Decline to state

What sex were you assigned at birth?

☐ Male ☐ Female ☐ Decline to state

Do you drink alcohol? ☐ No ☐ Yes If yes, how many drinks do you drink in an average week? ____

Have you ever used tobacco products? ☐ No ☐ Yes

If yes,

- product(s) used: ☐ Cigarettes ☐ Smokeless Tobacco ☐ Pipe ☐Cigar ☐ eCigarettes
- Are you still using tobacco products? ☐ No ☐ Yes

If you still use tobacco:

- Are you currently interested in quitting? ☐ No ☐ Yes
- How much do you use daily? ______ For how many years have you smoked? ______

If you quit smoking:

- How much did you smoke daily? ______ For how many years did you smoke?______

Do you have a Living Will or Advanced Directive? ☐ No ☐ Yes

Do you exercise at least 3 times a week? ☐ No ☐ Yes What type?____

Have you used recreation/illicit drugs: ☐ No ☐ Yes If yes, drug name/last used:__________________

Are you sexually active? ☐ No ☐ Yes Are your partners male / female / both? (circle)

Do you or your partner use contraception? ☐ No ☐ Yes What type?____________________________

What is your marital status? ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

With whom do you live?____

Occupation? _____________________
Are you currently ☐ Employed ☐ Unemployed ☐ Self Employed ☐ Retired

Patient (Guardian) Signature:____Date ________________

Physician Signature:____Date ________________