



NEW PATIENT QUESTIONNAIRE
SENIOR HEALTH PRIMARY CARE

THE FOLLOWING QUESTIONNAIRE IS INTENDED TO HELP US BETTER EVALUATE AND TREAT YOUR MEDICAL PROBLEMS. PLEASE COMPLETE IT TO THE BEST OF YOUR ABILITY. DO NOT HESITATE TO CONTACT US WITH ANY QUESTIONS.

NAME: _____ DATE: _____

ADDRESS: _____ AGE: _____

_____ DATE OF BIRTH: _____

PHONE: _____ CELL: _____

HOW DID YOU LEARN ABOUT MANCHESTER SENIOR HEALTH? _____

ALLERGIES (please list any allergies or sensitivities to medications, foods, dyes, environment)

ALLERGEN	REACTION
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_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS (please list all prescription medications, over-the counter medications, vitamins and supplements)

NAME	DOSAGE	FREQUENCY
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS (Continued)

PAST MEDICAL/SURGICAL HISTORY (please list all past and present illnesses, diseases, surgeries & Hospitalizations)

FAMILY HISTORY

DO YOU HAVE ANY BLOOD RELATIVES WHO HAD/HAVE, ANY OF THE FOLLOWING MEDICAL PROMBEMS?

(Please check all that apply)

Arthritis___ Alcohol Abuse___ Breathing Problems___ Bleeding Problems___ Blood Clots___
Diabetes___ Gallbladder Disease___ Heart Disease___ High Blood Pressure___ Lung Disease___
Liver Disease___ Kidney Disease___ Mental Illness___ Stroke___ Thyroid Disease___
Cancer___ (If yes, what type(s)?

Mother’s age (or age at death) _____ Alive? Yes___ No___

Mother’s Medical Problems:

Father’s age (or age at death) _____ Alive? Yes___ No___

Father’s Medical Problems:

CURRENT HISTORY

Do you presently have any problems with the following? If yes, please explain.

HEART: _____ MEMORY: _____

BREATHING: _____ HEAD: _____

DIGESTION: _____ SLEEP: _____

WEIGHT: _____ FATIGUE: _____

BOWELS: _____ WEAKNESS: _____

URINATION: _____ ANXIETY: _____

SKIN: _____ DEPRESSION: _____

BACK/JOINTS: _____ MOBILITY: _____

EYES/VISION: _____ TEETH/MOUTH: _____

DO YOU WEAR GLASSES? YES ___ NO ___ IF YES, FOR WHAT PURPOSE? _____

DO YOU WEAR DENTURES? YES ___ NO ___
IF YES, PLEASE INDICATE: UPPER ___ LOWER ___ BOTH ___

DO YOU DRIVE? YES ___ NO ___

HAVE YOU HAD ANY ACCIDENTS LAST 6 MONTHS? YES ___ NO ___

ANY FALLS WITHIN THE PAST 3 MONTHS? YES ___ NO ___

ANY INJURIES FROM A FALL? YES ___ NO ___

ANY OTHER PROBLEMS NOT MENTIONED ABOVE? _____

HEALTH MAINTENANCE

LAST EYE EXAM: _____ LAST DENTAL EXAM: _____ LAST TETANUS SHOT: _____

LAST FLU SHOT: _____ HAVE YOU EVER HAD A PNEUMONIA VACCINE? YES ___ NO ___

LAST CHOLESTEROL TEST: _____ LAST COLONOSCOPY: _____

(FEMALES ONLY) LAST MAMMOGRAM: _____ LAST PAP SMEAR: _____

SOCIAL HISTORY

EDUCATION

YEARS COMPLETED OF HIGH SCHOOL: _____

YEARS COMPLETED OF COLLEGE: _____

OCCUPATION (please list all present and past occupations):

ALCOHOL/SMOKING

DO YOU CURRENTLY SMOKE CIGARETTES? YES ___ NO ___

PACKS PER DAY ___ #OF YEARS _____

CIGARETTE USE IN THE PAST? YES ___ NO ___

PACKS PER DAY ___ #OF YEARS _____ QUIT DATE _____

DO YOU CONSUME ALCOHOLIC BEVERAGES? YES ___ NO ___

IF YES, WHAT TYPE? _____

HOW MANY DRINKS PER DAY? _____ HOW MANY DRINKS PER WEEK? _____

IF YOU NO LONGER DRINK, DESCRIBE PAST CONSUMPTION OF ALCOHOLIC BEVERAGES:

DIETARY

HOW MANY MEALS DO YOU EAT DAILY? _____

WHAT TYPE OF FOODS DO YOU EAT? _____

DO YOU USE TABLE SALT? YES ___ NO ___

DO YOU DRINK CAFFEINATED BEVERAGES? YES ___ NO ___

IF YES, WHAT TYPE? _____ CUPS/DAY? _____

ACTIVITY

ARE YOU PHYSICALLY ACTIVE OR DO YOU EXERCISE? YES ___ NO ___

HOW MANY TIMES PER WEEK? _____

WHAT TYPE OF EXERCISE? _____

ADVANCED CARE DIRECTIVES

DO YOU HAVE ADVANCED CARE DIRECTIVES?

(Advanced care directives are specific instructions, prepared in advance, that are intended to direct your medical care if you become unable to do so in the future)

YES: _____ LIVING WILL: _____ DURABLE POWER OF ATTORNEY _____

NO: _____ WOULD YOU LIKE MORE INFORMATION? _____

LIVING ARRANGEMENTS

DO YOU LIVE: BY YOURSELF _____ WITH YOUR SPOUSE _____ OTHER _____

DO YOU LIVE IN: APARTMENT _____ ASSISTED LIVING _____ SENIOR HOUSING _____
SINGLE FAMILY HOME _____ OTHER _____

DO YOU RECEIVE ANY COMMUNITY RESOURCES AT HOME? YES ___ NO ___

IF YES, WHAT TYPE? _____

DO YOU HAVE FAMILY/FRIENDS TO ASSIST YOU? _____

DO YOU HAVE ANY PROBLEMS MANAGING THE AREAS BELOW?

FINANCES: _____

LIVING ARRANGEMENTS: _____

PAPERWORK: _____

APPOINTMENTS: _____

MEDICATIONS: _____

MEAL PREPARATION: _____

TRANSPORTATION: _____

Name of person completing this form: _____

Relationship (if not the patient): _____