EAST MOUNTAIN MEDICAL, LLC.

Family Practice

104 Quail Trail Unit B Edgewood, NM 87015

Initial Patient Questionnaire

Name (please print): _____ Today's Date: _____

Address: _____

_____

Date of Birth: _____ Age: _____

List of Medications:

Medication Name:	Dose:	Taken How Often?

*****Additional space for medications on the last page

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Allergy: Food and/or medications

Allergy: _____ **Reaction:** _____

Allergy: _____ **Reaction:** _____

Allergy: _____ **Reaction:** _____

Latex allergy: _____ Yes _____ No

Past Medical History:

Please check/circle if you have any of the following:

_____ ADHD (Attention Deficit Hyperactivity Disorder)

_____ Alcohol/substance use disorder

_____ Arthritis

type _____ location(s) _____

_____ Asthma

_____ Back pain, location _____

_____ Bleeding disorder, blood clot(s), anemia

_____ Cancer, location(s) _____

_____ Chest pains

_____ Congestive heart failure

_____ COPD, emphysema

_____ Chronic fatigue

_____ Eye problems

_____ Nerve disorder, parkinson's, MS

_____ Osteoporosis

_____ Psychiatric, PTSD, bipolar

depression, anxiety _____

_____ Seizures, dizziness, fainting

_____ Sexually transmitted disease

_____ Thyroid disease

_____ Urinary problems, frequent

infections, prostate enlargement,

kidney stones

_____ Unexplained weight change,

_____ gain or loss

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_____ Diabetes

_____ GERD

_____ Headaches

_____ Hearing problems

_____ Hearing problems

_____ Heart disease

_____ Heart murmur, irregularities

_____ Joint problems

_____ Kidney disease

_____ Liver disease, cirrhosis, hepatitis

_____ Lung disease, pulmonary fibrosis, chronic bronchitis, tuberculosis, asbestosis

_____ Pain, location _____

_____ Pediatric developmental condition

_____ Sexual dysfunction

_____ Skin disease, eczema, psoriasis

_____ Sleep apnea

_____ Other _____

_____ High blood pressure

_____ Muscle disorder, fibromyalgia

_____ Gynecological (female) issues

_____ High cholesterol

_____ Gastrointestinal issues

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Past Surgical History:

Date: **Procedure:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Social History:

_____ Married _____ Single _____ Divorced _____Widowed _____ Partnered _____ Separated

_____ Employed _____ Retired _____ Unemployed _____ Homemaker

Job title if applicable _____

_____ Number of children _____ Number of pregnancies _____ Number of live births

_____ Number of miscarriages _____ Number of stillbirths

_____ Alcohol use _____ Type _____ Amount per day/week

_____ Tobacco use _____Amount per day _____ Years of use

_____ Medical marijuana prescribed

_____ Illicit drug use IV/oral _____ Name of drug _____How often

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Family History: Circle alive(A) or deceased(D)

Mother: _____ (A/D) Father: _____ (A/D)

Sister(s): _____ (A/D) Brother(s): _____ (A/D)

_____ (A/D) _____ (A/D)

_____ (A/D) _____ (A/D)

Maternal grandmother: _____ (A/D) Maternal grandfather: _____ (A/D)

Paternal grandmother: _____ (A/D) Paternal grandfather: _____ (A/D)

Significant history in other family members: _____

_____

Health Care Maintenance:

Last mammogram: _____ Last colonoscopy: _____

Bone density scan: _____ Last pap: _____

Aortic ultrasound(check for aneurysm) : _____ Last blood in stool check: _____

Name (printed): _____

Signature: _____ **Date:** _____

Parent/POA: _____

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Additional medications:

Medication Name: **Dose:** **Taken How Often?**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient signature: _____ **Date:** _____