GFP

GENEVA FAMILY PRACTICE

302 Randall Road * Suite 202 * Geneva, IL 60134 * (630) 232-1818 * Fax (630) 232-1868
www.genevafamilypractice.com * GFP@GFP1.com

NEW ADULT PATIENT QUESTIONNAIRE

DATE: _____

NAME: _____ **DOB**: _____

ALLERGIES (include medication, foods, pollen, etc. *and* type of reaction, i.e.: hives, swelling etc.):

_____

_____

OCCUPATION (include any special hazards): _____

CURRENT MEDICATION (include birth control pills, Aspirin, and over-the-counter medication, supplements and vitamins): _____

_____

SURGERIES (include dates, hospital and surgeon): _____

_____

HOSPITALIZATIONS (include problem and date): _____

_____

SPECIALISTS (list other doctors you see and their specialties): _____

_____

DATE OF LAST TETANUS SHOT (specify if unknown): _____

Any recent weight change? ____ Yes ____ No **Loss (in lbs) _____ Gain (in lbs) _____**

Do you have an advance directive (Someone in charge of making your medical decisions in the event you are unable)? ___ Yes ___ No If so, list the name and telephone number of the person responsible:

_____

I smoke cigarettes ____ Yes ____ No **I drink alcohol ____ Yes ____ No**

 # packs per day? _____ **How often? _____ Amount? _____**

I use illicit drugs ___ Yes ___ No (if yes, what and how often?) _____

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ADULT MEDICAL HISTORY

For the following, check the first column if you have the listed condition and the second column if it runs in your family. If it runs in your family, please indicate the relationship.

	You	Family member	Relationship (aunt, son, etc.)
Diabetes	___	_____	_____
High blood pressure	___	_____	_____
Stroke	___	_____	_____
Heart Attack	___	_____	_____
Cancer	___	_____	_____
Other: _____	___	_____	_____
Other: _____	___	_____	_____

Please list the name, age and relationship for all persons currently living with you. Please mark the last space for any person who has seen a doctor here.

NAME	AGE	RELATIONSHIP TO YOU	DOCTOR

FOR WOMEN ONLY

Age periods began and/or ended? _____ **Number of known pregnancies:** _____

Frequency of periods: _____ **Number of live births:** _____

Number of flow days: _____ **# of miscarriages/abortions:** _____

Date of last Pap smear: _____ **Last Mammogram:** _____

Do you see another doctor for gynecological checkups? ___ Yes ___ No

If so, whom? _____

Any other information we should know that we haven't asked?

_____

_____