Cayuga
MEDICAL ASSOCIATES

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New Patient Health Questionnaire

Full Legal Name:	Preferred First Name:	Date of Birth:	Today's Date:

Street Address:	City and State:	Zip Code:

Email:

Home Phone:	Cell Phone:

Insurance Information

Primary Insurance
Primary Insurance: _____
Subscriber Name: _____
Subscriber Birth Date: ___/___/___
Insurance ID Number: _____
Insurance Group Number: _____

Secondary Insurance
Secondary Insurance: _____
Subscriber Name: _____
Subscriber Birth Date: ___/___/___
Insurance ID Number: _____
Insurance Group Number: _____

Prescription Insurance: *if applicable*
Primary Insurance: _____
Subscriber Name: _____
Subscriber Birth Date: ___/___/___
Insurance ID Number: _____
Insurance Group Number: _____

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General Health Information

1. Who was your last primary care provider: _____

2. How would you describe your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

3. Please list all current medications, vitamins, supplements, and over-the-counter medications taken. Please include name, dosage, and how often you take it:

MEDICATION:	DOSE:	HOW OFTEN YOU TAKE IT:

4. Please list all health problems, including those that you take medication for:

_____ _____

_____ _____

_____ _____

_____ _____

5. Please specify any specialists you are currently seeing or have seen in the last 3 years.

☐ Cardiology
☐ Neurology
☐ Pulmonology
☐ Orthopedics
☐ Rheumatology
☐ Nephrology (kidneys)
☐ Urology
☐ Endocrinology
☐ Mental Health
☐ Women's Health
☐ Not listed, other: _____

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6. Please list all allergies you have along with the type of reaction:

DRUG/FOOD/OTHER TRIGGERS:	TYPE OF REACTION:

7. Have you ever received a Flu shot?
   ☐ Yes Date of latest dose: _____
   ☐ High Dose Date of latest dose: _____
   ☐No

8. Have you received a Tetanus shot?
   ☐ Yes, TDAP Date of latest dose: _____
   ☐ Yes, Td Date of latest dose: _____
   ☐ No

9. Have you received a Pneumonia shot?
   ☐ Yes, Pneumovax Date of latest dose: _____
   ☐ Yes, Prevnar 13 Date of latest dose: _____
   ☐ Yes, PCV 20 Date of latest dose: _____
   ☐ No

10. Have you had the Shingrix vaccine series?
    ☐Yes ☐ No Date dose 1: _____
    Date dose 2: _____

11. Have you ever had the HPV/Gardasil vaccine series?
    ☐ Yes ☐ No Date dose 1: _____
    Date dose 2: _____
    Date dose 3: _____

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12. Have you received the Covid-19 vaccine?
    - ☐ Yes, Pfizer
    - ☐ Yes, Moderna
    - ☐ Yes, Johnson & Johnson
    - ☐ Yes, Novavax
    - ☐ No

    Date of latest dose: _____

13. Have you received a Covid-19 booster shot?
    - ☐ Yes, Pfizer
    - ☐ Yes, Moderna
    - ☐ Yes, Novavax
    - ☐ No

    Date of latest dose: _____

Screenings

14. Have you ever been pregnant? ☐ Yes ☐ No
    How many times? _____
    How many children have you given birth to? _____

15. Have you had a PAP smear? ☐ Yes ☐ No
    Date of most recent screening: _____
    Result: ☐ Normal ☐ Abnormal, please explain: _____

16. Have you ever had an AAA screening (abdominal aortic aneurysm)? ☐ Yes ☐ No
    Date of most recent screening: _____
    Result: ☐ Normal ☐ Abnormal, please explain: _____

17. Have you had a mammogram? ☐ Yes ☐No
    Date of most recent screening: _____
    Result: ☐ Normal ☐ Abnormal, please explain: _____

18. Have you ever had a colonoscopy? ☐ Yes ☐ No
    Date of most recent screening: _____
    Result: ☐ Normal ☐ Abnormal, please explain: _____

19. Have you ever had a DEXA scan (assess risk of osteoporosis)? ☐ Yes ☐ No
    Date of most recent screening: _____
    Result: ☐ Normal ☐ Abnormal, please explain: _____

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20. Have you ever had a Hepatitis C screening? ☐ Yes ☐ No
    Date of most recent screening: _____
    Result: ☐ Positive ☐ Negative
    If positive, are you currently or have you had treatment? ☐ Yes ☐ No
    If yes, please explain details of treatment plan: _____

Social History

21. What is your marital status?
    ☐Single ☐Divorced
    ☐Partnered ☐Separated
    ☐Married ☐Widowed

22. Are you currently sexually active? ☐ Yes ☐ No
    a. If yes, what type of intercourse do you have? ☐ vaginal ☐ anal ☐ oral ☐ other
    b. Who do have sex with? ☐ men ☐ women ☐ both ☐ other gender identity
    c. Do you and your partner use contraceptives? ☐ Yes ☐ No
    d. What type of contraceptives do you use? ☐ Condoms ☐ Hormonal Contraceptives ☐ IUD ☐ Other

23. Have you been sexually active in the last year? ☐ Yes ☐ No

24. Who lives in your household:
    _____
    _____

25. What do you do during the day?
    ☐ Work full-time
    Occupation: _____
    ☐ Work part-time
    Occupation: _____
    ☐ Attend school
    ☐ Take care of household/family
    ☐ Not currently working
    ☐Retired
    ☐Other: _____

26. Is there anyone in your life currently threatening or hurting you? ☐ Yes ☐ No

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Health Habits

27. Do you drink alcohol?
    - ☐ No
    - ☐ Yes
        a. If yes, how many drinks do you have in an average week? _____
        (*Note: 1 drink is equivalent to 12 oz. beer, 5 oz. wine or 1.5 oz. hard alcohol)*
        b. Are you or the people around you concerned about how many drinks? ☐ Yes ☐ No
        c. In the past year have you ever had 4+ drinks in one day? ☐ Yes ☐ No
        d. If yes, how often do you have 4+ drinks in one day? _____

28. Have you ever smoked cigarettes or cigars?
    - ☐ No
    - ☐ Yes
        a. If yes: ☐ I smoked in the past ☐ I am a current smoker
        b. If you are a current smoker, how many packs per day: _____
        c. If you are a former smoker, what age did you quit: _____
        d. Do you use other forms of tobacco? ☐ Yes ☐ No
        e. If yes, what type: _____
        f. Have you ever vaped or used e-cigarettes? ☐ Yes ☐ No
            a. If yes: ☐ I smoked in the past ☐ I am a current smoker

29. Do you use any other substances, legal or not?
    - ☐ No
    - ☐ Yes
        a. If yes, is your use: ☐ Regular ☐ Infrequent
        b. If yes, please list out the substance(s):
        _____
        c. Have you used other substances in the past? ☐ Yes ☐ No

30. Do you exercise: ☐ Rarely ☐ Occasionally ☐ Regularly
    a. What do you do for exercise? _____
    _____
    _____

31. Are you on any special diets? ☐ No ☐ Yes, please specify: _____

32. Have you fallen in the past 6 months? ☐ No ☐ Yes

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Family History

33. Do you have a family history of mental illness, depression, anxiety, alcohol or substance abuse?
☐ No ☐ Yes

34. What medical problems do your family members have:

RELATIONSHIP:	**LIVING? YES/NO**	**CURRENT AGE:**	**SIGNIFICANT HEALTH PROBLEMS:** (*please list all health concerns which may include diabetes, heart disease, hypertension, cancer, etc.)*
Mother			
Father			
Sibling			
Sibling			
Maternal Grandfather			
Maternal Grandmother			
Paternal Grandfather			
Paternal Grandmother			
Other Family			

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History of Surgeries & Procedures

35. Please list any and all surgeries/procedures you have received:

PROCEDURE:	DATE:

Please include any additional information you want us to know or purpose of your visit:

_____
_____
_____
_____
_____
_____