# TRIANGLE FAMILY CARE, P.A.

New Patient/Existing Patient Update Questionnaire

***(CONFIDENTIAL)***

**Date Completed: _____ Name: _____** DOB***:*** _____

**Please circle any medical problems that you have now or have had*:***
Diabetes, high blood pressure (hypertension), asthma, allergies, depression, anxiety, thyroid problems, arthritis, HIV, migraines, anemia, high cholesterol, cancer (please specify: _____)

**Please list any other medical problem not listed above that you have now or have had:**
_____

**Please list any surgeries you have had and the year you had the surgery, if you know it:**
_____

**Please list all medications that you take and the dosages and frequency (please include prescribed and over-the-counter medicines, including vitamins, minerals and herbs):**
_____
_____
_____

**Please list any allergies to medications and list non-mediation allergies as well:**
_____

**From what country or area of the country (i.e. state) are you? _____**

**What is/was your occupation?: _____**

**Do you exercise regularly?** (circle) Yes No **If yes, how often and what form of exercise? _____**

**Do you now smoke?** (circle): Yes No **If yes, how many per day? ____ and for how many years? __**

**Did you ever smoke?** (circle): Yes No **If yes, when did you quit? _____**

**Do you drink alcohol?** (circle): Yes No **If yes, on average, how many drinks per week? _____**

**Do you drink caffeine?** (circle): Yes No **If yes, on average, how many drinks per day? _____**

**Do you currently use any drugs like marijuana or cocaine?** (circle): Yes No **If yes, please explain to the doctor.**

**Marital Status: Are you** (circle all that apply): single, married, widowed, divorced, separated

**If married, what is your spouse's name: _____**

**If single, widowed, divorced or separated, do you have a significant other (boyfriend/girlfriend)?:** Yes No

**List the names of your children (if any)**: _____

**How do you describe your gender?** (circle): Male, Female, Transgender (MTF or FTM), Non-binary

**How would you describe your sexual orientation?** (circle): heterosexual (straight), homosexual (gay), bisexual, asexual, don't know, prefer to discuss in person with provider

**Do you observe a particular religion or faith?** (circle): Yes No **If yes, please name: _____**

**Do you feel safe at home (please circle)?** Yes No Prefer to discuss in person with provider

**Do you have:? (please circle all that apply):** Living Will, Healthcare POA, MOST form, DNR form

**(continued on back)**

# TRIANGLE FAMILY CARE, P.A.

**Circle any medical problems that run in your FAMILY and list which relative has the condition (Mom, Dad, S=sister, B=brother, M=maternal, P=paternal, GM=grandmother, GF=grandfather):**

Breast cancer: _____ High blood pressure: _____ Alcoholism: _____
Colon cancer: _____ Diabetes: _____ Depression: _____
Skin cancer: _____ Thyroid problems: _____ Parkinson's: _____
Prostate cancer: _____ Heart attacks/disease: _____ Alzheimer's: _____
Lung cancer: _____ Strokes: _____ Lymphoma: _____
Leukemia: _____ High cholesterol: _____ Other: _____

## For all patients over the age of 18:

**Have you ever had your cholesterol level checked?** (circle) Yes No **If yes, when was the last time and what was the result?** Date: _____Total:_____HDL:_____LDL_____TG _____
**When was your last tetanus shot or booster? :** _____
**Do you use your seat belt regularly?:** (circle) Yes No
**If you ride a motorcycle or bicycle, do you always wear a helmet?** (circle) Yes No N/A
**Is/are your sexual relationship/s entirely satisfactory?** (circle) Yes No **If no, please explain:**
_____
**What form of contraception do you use, if any?**_____
**If it's between October 1 and April 1, have you had the flu shot?** Yes No
**When was your last eye exam?** _____
**When was your last dental exam?** _____

## For all patients over the age of 40 (for men) 50 (for women):

**Do you take at least a baby aspirin per day?** (circle) Yes No

## For all patients over the age of 50:

**Have you ever had a screening test for colon or rectal cancer** (like a colonoscopy, flex sig or air-contrast barium enema)? (circle) Yes No **If yes, when was the last one done?** _____
**Have you received the Shingles Vaccine (Zostavax or Shingrix)** Yes No Don't know If yes, when?_____

## For all patients over the age of 65:

**Have you had the pneumococcal vaccine (PCV23)?** Yes No Don't know
**Have you had the Prevnar vaccine (PCV13)?** Yes No Don't know

## For WOMEN only:

***When was your last menstrual period?*** _____
***Was it normal for you?*** (circle) Yes No ***If no, please explain:*** _____
***When was your last pap smear?*** _____
***Have you ever had an abnormal pap smear?*** Yes No ***If yes, please explain:*** _____
***When was your last mammogram?*** _____
***When was the last time you had a physician or healthcare professional do a breast exam?*** _____
***Do you do monthly self-breast exams?*** (circle) Yes No
***How many times have you been pregnant?*** _____
***How many pre-term babies have you delivered?*** _____
***How many term babies have you delivered?*** _____
***How many abortions or miscarriages have you had?*** _____
***How many of your children are now living?*** _____
***Do you prefer to have a woman do your pap smears, pelvic exams and breast exams?*** (circle) Yes No Doesn't matter

## For MEN only:

***When was your last prostate exam (digital rectal exam)?*** _____
***Have you ever had the blood test, PSA done?*** (circle) Yes No ***If yes, when was the last time?*** _____
***Do you do monthly self-testicular exams?*** (circle) Yes No

## Do you have any particular health concerns? (circle) Yes No *If yes, please explain:*

_____