**** This form may be done online by visiting:
https://www.myupdox.com/portal/osteopathicfamilymedicine/html/publicform-15843.html

Osteopathic Family Medicine, LLC - Aaron Way, D.O.

Available Forms

- Depression Screening Questionaire (PHQ-9)
- Medicare Health Risk Assessment
- New Patient Questionnaire
- Patient Satisfaction Survey - CAHPS/PCMH Version 3.0

New Patient Questionnaire

Welcome to our practice. We greatly appreciate your choosing us to provide care for your family. Our providers will be asking you about your present medical condition and problems, but to allow us to learn more about you, please fill out this questionnaire. Although some questions may be a little startling, please understand that they address current health issues. Once again, thank you for choosing our practice to handle your health care needs.

Name *

Date of Birth *

When was your last comprehensive health examination (blood tests, EKGs, etc.)?

If you were born after 1957, have you had a second measles, mumps and rubella vaccination?
O YES
O NO

If you are at least 65 years old or have a chronic health problem, have you received the pneumococcal and flu vaccines?
O YES
O NO

Females

If you are a female, do you do a monthly self-breast exam?
O YES
O NO

When was your last breast exam by your physician?

Date of last mammogram:

Date of last pap smear:

Note: One out of every 10 women will get breast cancer. The best approach is early detection by doing a monthly self-breast exam, an annual breast exam by your physician and periodic mammograms.

Post-Menopausal Women - What age was your last period?

Males

If you are a male, do you do a monthly self-testicular exam?
O YES
O NO

Note: Testicular cancer is a leading cause of cancer for men under the age of 50.

Everyone

Do you practice safe sex?	○ YES ○ NO
Are you at risk for AIDS?	○ YES ○ NO
Have you used illegal drugs?	○ YES ○ NO
What is your occupation?	
Have you ever been exposed to chemicals or radiation at the workplace?	○ YES ○ NO
Do you have a living will?	○ YES ○ NO
If there is a gun in your home, is it out of children's reach and unloaded?	○ YES ○ NO
If you ride a bicycle, do you wear a bike helmet?	○ YES ○ NO
Is your home tobacco- and smoke-free?	○ YES ○ NO
If you use tobacco, how much and in what form do you use	
If you use tobacco, what age did you start?	
Is your time well balanced between your job, family and hobbies?	○ YES ○ NO
If you are over 50 have you had any of the following?	☐ Colonoscopy ☐ Density testing ☐ EKG ☐ Specialist Evaluation ☐ Hepatitis C testing
If you checked any of the above, please explain the details of the test/findings.	
Do you have any of these conditions:	☐ Coronary artery disease ☐ Hypertension (elevated blood pressure) ☐ Diabetes ☐ High cholesterol ☐ Congestive heart failure ☐ Chronic bronchitis (COPD) ☐ Asthma ☐ Renal (kidney) disease ☐ Cancer ☐ Liver disease ☐ Sexually Transmitted disease ☐ Alcoholism ☐ Drug dependence

	☐ HIV infection
Do you have any other medical history not listed above?	
If you have had surgery, please explain:	
If you have allergies to medications, please list and explain your reaction.	
Does YOUR BIOLOGICAL FATHER have any of these conditions?	☐ Coronary artery disease ☐ Hypertension (elevated blood pressure) ☐ Diabetes ☐ High cholesterol ☐ Congestive heart failure ☐ Chronic bronchitis (COPD) ☐ Asthma ☐ Renal (kidney) disease ☐ Cancer ☐ Liver disease ☐ Alcoholism ☐ Drug dependence ☐ Mental Illness
Does YOUR BIOLOGICAL MOTHER have any of these conditions?	☐ Coronary artery disease ☐ Hypertension (elevated blood pressure) ☐ Diabetes ☐ High cholesterol ☐ Congestive heart failure ☐ Chronic bronchitis (COPD) ☐ Asthma ☐ Renal (kidney) disease ☐ Cancer ☐ Liver disease ☐ Alcoholism ☐ Drug dependence ☐ Mental Illness
Do any of YOUR BIOLOGICAL SIBLINGS have any of these conditions?	☐ Coronary artery disease ☐ Hypertension (elevated blood pressure) ☐ Diabetes ☐ High cholesterol ☐ Congestive heart failure ☐ Chronic bronchitis (COPD) ☐ Asthma ☐ Renal (kidney) disease ☐ Cancer ☐ Liver disease ☐ Alcoholism ☐ Drug dependence ☐ Mental Illness
Do any of YOUR BIOLOGICAL CHILDREN have any of these diseases?	☐ Coronary artery disease ☐ Hypertension (elevated blood pressure) ☐ Diabetes ☐ High cholesterol ☐ Congestive heart failure ☐ Chronic bronchitis (COPD) ☐ Asthma ☐ Renal (kidney) disease ☐ Cancer ☐ Liver disease

☐ Alcoholism
☐ Drug dependence
☐ Mental Illness

Are there any other diseases in your immediate family not listed above?

Preferred Pharmacy and Location:

Preferred lab and location:

Please bring all medications and supplements you are currently taking to your first visit.

List any other doctors you are currently seeing:

Who was your previous PCP (Primary Care Physician)?

When did you last see a Primary Care Physician?

* Required field

Submit Form