Fireweed Health Care, Inc.

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New Patient PRIMARY CARE Questionnaire

Name_____ **Date**_____

Which pharmacy will you be using? _____

What are your main medical concerns? _____

_____

PERSONAL AND FAMILY HEALTH HISTORY

(Please check-mark each item you or a family member has been diagnosed with)

	Self	Family		Self	Family
Cancer	☐	☐	Sleep Apnea	☐	☐
Heart Disease	☐	☐	Asthma	☐	☐
High Blood Pressure	☐	☐	COPD/Emphysema	☐	☐
Heart Attack	☐	☐	Osteoporosis	☐	☐
Stroke	☐	☐	Hepatitis B or C	☐	☐
Seizures	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Headaches/Migraines	☐	☐
Thyroid Problems	☐	☐	Anemia	☐	☐
Kidney Disease	☐	☐	Bowel Disorders	☐	☐

Please list all hospitalizations and surgeries you have ever had:

Surgery	Year	Hospital

Allergies:

What are you allergic to?	What is your reaction?	Do you require treatment?

Current Medications and Supplements: *Please list ALL prescriptions and over-the-counter (OTC) medications or supplements you are CURRENTLY taking.*

Name of Medication/Supplement/Ointment	Strength	How often each day?

REVIEW OF SYSTEMS

(Check the boxes of each symptom you have experienced in the past 30 days.)

Constitutional:

- ☐ Fatigue
- ☐ Restlessness
- ☐ Fever
- ☐ Chills
- ☐ Hot flashes
- ☐ Cold flushes
- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Weight gain
- ☐ Weight loss
- ☐ Night sweats

Skin:

- ☐ Rash
- ☐ Hives
- ☐ Sweating
- ☐ Excessive itching
- ☐ Sores
- ☐ Goosebumps
- ☐ Blisters
- ☐ Painful lesions
- ☐ Moles changing size, shape or color

HEENT:

- ☐ Nasal congestion
- ☐ Runny nose
- ☐ Sore throat
- ☐ Loss of teeth
- ☐ Dentures
- ☐ Cavities/gum disease
- ☐ Dry mouth
- ☐ Loss of taste
- ☐ Loss of smell
- ☐ Yawning
- ☐ Watery eyes
- ☐ Visual changes
- ☐ Ringing in ears
- ☐ Hearing loss

Cardiovascular:

- ☐ Chest pain
- ☐ Heart racing
- ☐ Lightheaded
- ☐ Palpitations
- ☐ High blood pressure
- ☐ Swollen ankles or legs

Respiratory:

- ☐ Shortness of breath
- ☐ Cough
- ☐ COPD/emphysema
- ☐ Wheezing
- ☐ Sleep Apnea

Musculoskeletal:

- ☐ Twitching
- ☐ Weakness
- ☐ Shaking
- ☐ General body aches
- ☐ Joint swelling
- ☐ Morning stiffness
- ☐ Bone aches
- ☐ Cramps
- ☐ Muscle aches
- ☐ Joint pain
- ☐ Joint redness

Genitourinary:

- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ Pain w/urination
- ☐ Leaky bladder
- ☐ Loss of bladder control

If female: Are you pregnant? ☐ Yes ☐ No

Date of last cycle: _____

Please notify us immediately if you become pregnant.

Gastrointestinal:

- ☐ Nausea
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Stomach cramps
- ☐ Loss of bowel control
- ☐ Abdominal pain, cramping or distension
- ☐ Vomiting
- ☐ Constipation
- ☐ Red blood in stool
- ☐ Black, tarry stool
- ☐ Yellow eyes or skin

Bowel Movements are:

- ☐ Daily
- ☐ Every other day
- ☐ 2x/week
- ☐ Every 5-6 days
- ☐ Once weekly

Is this your normal frequency? ☐ Yes ☐ No

Is this ☐ LESS or ☐ MORE frequent than normal?

Neurological:

- ☐ Tremors
- ☐ Tingling
- ☐ Fainting
- ☐ Frequent falls
- ☐ Numbness
- ☐ Headache
- ☐ Seizures
- ☐ Involuntary movements

Endocrine:

- ☐ Diabetes
- ☐ Excessive thirst
- ☐ Heat/Cold Intolerance
- ☐ Thyroid Issues
- ☐ Low libido

Hematologic/Lymphatic:

- ☐ Abnormal bleeding
- ☐ Swollen lymph nodes
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Bruising easily
- ☐ Lymphedema
- ☐ Clotting disorder

Immunologic/Allergic:

- ☐ Asthma
- ☐ Current cold
- ☐ Seasonal allergies
- ☐ Current flu

Psychiatric

- ☐ Suicidal thoughts
- ☐ Anxiety
- ☐ Depression
- ☐ Craving drugs
- ☐ Anger issues
- ☐ Irritability
- ☐ Changes in mood
- ☐ Homicidal thoughts
- ☐ Hallucinations
- ☐ Difficulty sleeping
- ☐ Panic attacks
- ☐ Hearing voices

MENTAL HEALTH DIAGNOSIS HISTORY

*Please **check-mark** any of the following issues **you have now or have had in the past**.*

▢ Suicidal thoughts	▢ Homicidal thoughts	▢ PTSD	▢ ADD/ADHD
▢ Anger	▢ Hearing voices	▢ Anxiety	▢ Eating Disorders
▢ Irritability	▢ Hallucinations	▢ Depression	▢ OCD
▢ Changes in mood	▢ Schizophrenia	▢ Panic attacks	
▢ Difficulty sleeping	▢ Bi-polar disorder	▢ Personality Disorders	

Do you have any thoughts of suicide or of wanting to hurt yourself or others? ▢ Yes ▢ No

If yes, do you have a plan? ▢ Yes ▢ No If yes, please describe _____

_____

Have you ever attempted suicide in the past? ▢ Yes ▢ No If yes, when and what method did you use?

_____

Quality of Sleep: ▢ Good ▢ Fair ▢ Poor Number of hours nightly? _____

Do you suffer from insomnia? ▢ Yes ▢ No

Are you diagnosed with sleep apnea? ▢ Yes ▢ No If yes, do you use CPAP/BiPAP? ▢ Yes ▢ No

Nicotine Use:

Do you use nicotine? ▢ Yes ▢ No If yes, what form? _____

Average daily amount: _____ Would you like help quitting now? ▢ Yes ▢ No

Would you be interested in quitting at some time in the future? ▢ Yes ▢ No

Alcohol Use

Do you drink alcohol? ▢ Yes ▢ No When was your most recent use? _____

How often do you drink? ▢ Most days ▢ Weekly ▢ Monthly ▢ Special occasions ▢ _____

Approximately how many standard drinks do you normally consume? _____

What kind of alcohol do you consume? ▢ Beer ▢ Wine ▢ Wine coolers ▢ Liquor

Are you in recovery from alcohol addiction or abuse? ▢ Yes ▢ No Recovery date: _____

Stop Bang Questionnaire

Do you snore loudly? (Louder than talking or loud enough to be heard through closed doors)	▢ Yes ▢ No
Do you often feel tired, fatigued, or sleepy during the daytime?	▢ Yes ▢ No
Has anyone observed you stop breathing during sleep?	▢ Yes ▢ No
Do you have (or are you being treated for) high blood pressure?	▢ Yes ▢ No

Age: _____ Gender: ▢ Male ▢ Female Neck Circumference: _____cm

(MA will obtain this for you)

Generalized Anxiety Disorder (GAD-7) Questionnaire

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	▢	▢	▢	▢
2. Not being able to stop or control worrying.	▢	▢	▢	▢
3. Worrying too much about different things.	▢	▢	▢	▢
4. Trouble relaxing.	▢	▢	▢	▢
5. Being so restless that it's hard to sit still.	▢	▢	▢	▢
6. Becoming easily annoyed or irritable.	▢	▢	▢	▢
7. Feeling afraid as if something awful might happen.	▢	▢	▢	▢
	XXXXXX			
Total Score	XXXXXX	XXXXXX	XXXXXX	

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

CAGE-AID Questionnaire - At any time in your life, have you:

Have you ever felt that you ought to **cut down** on your drinking or drug use?	▢ Yes ▢ No
Have people **annoyed** you by criticizing your drinking or drug use?	▢ Yes ▢ No
Have you ever felt bad or **guilty** about your drinking or drug use?	▢ Yes ▢ No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (**eye-opener**)?	▢ Yes ▢ No

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle your response)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	▢	▢	▢	▢
2. Feeling down, depressed, or hopeless.	▢	▢	▢	▢
3. Trouble falling or staying asleep, or sleeping too much.	▢	▢	▢	▢
4. Feeling tired or having little energy.	▢	▢	▢	▢
5. Poor appetite or overeating.	▢	▢	▢	▢
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down.	▢	▢	▢	▢
7. Trouble concentrating on things, such as reading the newspaper or watching television.	▢	▢	▢	▢
8. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	▢	▢	▢	▢
9. Thoughts that you would be better off dead, or of hurting yourself.	▢	▢	▢	▢
	XXXXX			
Total	XXXXX	XXXXX	XXXXX	

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____