UW Medicine
UW NEIGHBORHOOD CLINICS

New Patient Health Questionnaire

Name ______________________________ Birth Date ______________ **Today's Date** ______________

Your answers to the following questions will help us understand your medical history. Please fill out as much information as possible. If you cannot answer a question or feel uncomfortable answering a question, please leave them blank. Thank you for your help.

Over the last two weeks, how often have you been bothered by any of the following problems? *(please circle the number to indicate your answer)*

	Not at all	Several days	More than half of the days	Nearly all of the days
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Medical History *(Please check or list any medical problems you have experienced.)*

☐ Asthma (493.2)	☐ Anxiety (300.00)	☐ Cancer / Type
☐ Depression (311)	☐ Diabetes (250.00)	☐ High blood pressure (401.9)
☐ High cholesterol (272.4)	☐ Thyroid disease (246.9)	☐ Other:

Prescription Medications *(Please list medications you take and what condition they are prescribed for. If necessary, turn paper over for additional lines.)*

Medication	Condition

Medication Allergies *(Please list the name of the medication and the reaction you experienced. If necessary, turn paper over for additional lines.)*

Medication	Reaction

Health Habits *(Please circle or note the appropriate answer.)*

Tobacco Use:						
Smoking status/history	I smoke everyday		I smoke some days		I am a former smoker	
	I am a passive smoker (live with others who smoke)				I have never smoked	
If you are a current smoker, how many packs per day?	¼	½	1	1.5	2	3
Smokeless tobacco status/history	Current user		Former user		Never used	
If you use any type of tobacco, are you ready to quit?	No / Yes					

Alcohol Use:			
Do you drink alcohol?	Yes	No	Quit
Note the number of each item you drink per week	Glasses of wine ___	Cans/bottles of beer___	Shots of liquor ___
Recreational Drug Use:			
Do you use recreational drugs?	No / Yes		

Surgical History *(Please list all previous surgeries and the year they occurred. If necessary, overflow space is included below.)*

Surgery	Year

Family History *(Please place a check mark in the box if any of these diseases run in your immediate family.)*

	Mother	Father	Brother	Sister
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐

Sexual History *(Please circle or note the appropriate answer)*

Are you sexually active?	No / Yes		
With?	Men	Women	Both
Do you use any form of birth control?	No	Yes	If yes, what type?
Women Only:			
Have you ever been pregnant?	No	Yes	If yes, how many times?
Number of:	Miscarriages ___	Abortions ___	Living children ___

Thank you very much for your time, your medical history is very important to us!

Prescription Medications Overflow *(Please list medications you take and what condition they are prescribed for.)*

Medication	Condition

Medication Allergies Overflow *(Please list the name of the medication and the reaction you experienced.)*

Medication	Reaction

Surgical History Overflow *(Please list all previous surgeries and the year they occurred.)*

Surgery	Year