Frontier Health and Wellness

Patient History Questionnaire (Adult)

To better assist our providers, we are asking that you complete the following questionnaire prior to your initial appointment. If you need more space, please feel free to add pages as needed.

Patient Name:			I	ate of	f Birth: _								
Please provide a list o	f your pre	vious (l	last 5 years) ar	nd curr	ent medic	al and m	ental	health pro	oviders				
Provider Type			Provide			Clinic/Hospital Name			Phone Number		Location (City/State)		
Primary Care Provid		N/A				,							
Previous Primary Ca	are Provid	er											
(last 5 years)		J/A											
Specialist(s) (Cardio													
Allergy, Pulmonolog		N/A											
Specialist(s) (Cardio													
Allergy, Pulmonolog		N/A											
Therapy		N/A											
Psychiatry		N/A											
Neuropsych Testing		N/A											
Other:		N/A											
Other:	I	N/A											
Please list all the medi	ications vo	ii are ci	urrently takin	or □N	J/A								
Medication Name		osage	urciny takin	ently taking: N/A Frequency				Taking for how long?		Side effects/concerns?			
1720dicadori i turro		Dosage			Frequency			Taking for now long.			blue cheedy concerns:		
Please list all of your p	revious ps	sychiatr	ric medication	n: 🗌 N	I/A								
Medication Name		osage			equency			Taking f	or how long?	Sic	le effects/cor	ncerns?	
National Property of the Parket Property of t										1 110 11 101191 510			
Please list all supplem	ents/over	the cou	ınter medicat	ions yo	u are curre	ently taki	ng: [N/A					
Medication Name Dosage					Frequency				or how long?	Sic	le effects/cor	ncerns?	
											, , , , , , , , , , , , , , , , , , ,		
	•												
Please list any of you	ur known	allerg	ies as well as				s:	No know					
Allergen					ty of Reac				T	ype of	Reaction		
			Mild		Moderate		_	evere					
			Mild		Moderate			evere					
			Mild		Moderate			evere					
			Mild		Moderate	;	Se	evere					
Current or previous	substanc	ce use:	N/A					CTT					
Substance			T x x 7 1 1	710	.1			of Use	1				
Caffeine	Dai] Weekly		month			ally/Social			or twice	Never	
Tobacco/Vaping	Dai] Weekly		month	Occasionally/Social Occasionally/Social				or twice	Never		
Alcohol	Dai] Weekly [month						or twice	Never	
Opioids/	Dai	ıy L] Weekly	1-2x	month	☐ Occ	asion	ally/Social	ıy 🔲 Fried i	t once	or twice	Never	
Prescription Drugs		1,, [Woold. I	1.0	month			olly/C: 1	l., Tr.:. 1 :	t on a :	on troises	Never	
Marijuana	Dai		Weekly Weekly		month			ally/Social ally/Social			or twice	Never	
Hallucinogens Amphetamines	Dai		Weekly [month			ially/Social ially/Social			or twice or twice	Never	
Other:			Weekly		month			ially/Social			or twice	Never	
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Family Medical History: N/A Medical Condition	Patient	or Family His	torv	Please list the Family Member(s) affected				
Anemia	Patient		History	Trease list the Fairniy Wes	inder (b) directed			
Asthma/Respiratory Concerns	Patient		History					
Cancer	Patient		History					
Chronic Fatigue	Patient		History					
Concussion(s) or TBI	Patient		History					
Diabetes	Patient	Family	History					
Epilepsy/Seizures	Patient	☐ Family	History					
Heart Disease/Condition	☐ Patient	☐ Family	History					
High Blood Pressure	Patient	☐ Family	History					
Insomnia	Patient	☐ Family	History					
Stomach/ GI Problems	Patient		History					
Stroke	Patient		History					
Substance Abuse	Patient		History					
Thyroid Disease	Patient	Family	History					
Psychiatric history: N/A								
Psychiatric Condition		or Family His		Please list the Family Member(s) affected				
ADHD	Patient	☐ Family	History					
Anger	Patient	Family	History					
Anxiety	Patient	☐ Family	History					
Bi-Polar Disorder	Patient	☐ Family	History					
Depression	Patient	Family	History					
Inpatient Psychiatric Care	Patient	☐ Family	History					
OCD	Patient	☐ Family	History					
PTSD	Patient	☐ Family	History					
Schizophrenia	Patient	Family	History					
Suicide	Patient	☐ Family	History					
Please list any of your surgical histo	yry or hospitalis	zations N/A						
Surgery/Reason for Hospitalizati		ate(s)	Hospital	Doctor/Attending	Location (City, State)			
Surgery/Reason for Frospitalizati		acc(s)	Поэрна	Doctor/Machanig	Location (City, State)			
TT 1 1 11 1 1	1 / 1 //1 //	1	/:C 1 1	14 11 4 1 1 1 7	TAY DAT			
Have you had any bloodwork com	pleted within th	ne last 6 montl	ns (if yes, who ordere	ed the labs to be drawn):	」Yes □ No			

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