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: _____ Date of Birth: _____

Please provide a list of your previous (last 5 years) and current medical and mental health providers

Provider Type	Provider Name	Clinic/Hospital Name	Phone Number	Location (City/State)
Primary Care Provider N/A				
Previous Primary Care Provider (last 5 years) N/A				
Specialist(s) (Cardio, Neuro, Allergy, Pulmonology etc.) N/A				
Specialist(s) (Cardio, Neuro, Allergy, Pulmonology etc.) N/A				
Therapy N/A				
Psychiatry N/A				
Neuropsych Testing N/A				
Other: N/A				
Other: N/A				

Please list all the medications you are currently taking: ☐ N/A

Medication Name	Dosage	Frequency	Taking for how long?	Side effects/concerns?

Please list all of your previous psychiatric medication: ☐ N/A

Medication Name	Dosage	Frequency	Taking for how long?	Side effects/concerns?

Please list all supplements/over the counter medications you are currently taking: __ N/A

Medication Name	Dosage	Frequency	Taking for how long?	Side effects/concerns?

Please list any of your known allergies as well as the reaction that occurs: ☐ **No known allergies**

Allergen	Severity of Reaction			Type of Reaction
	☐ Mild	☐ Moderate	☐ Severe	
	☐ Mild	☐ Moderate	☐ Severe	
	☐ Mild	☐ Moderate	☐ Severe	
	☐ Mild	☐ Moderate	☐ Severe	

Current or previous substance use: ☐ N/A

Substance	Frequency of Use					
Caffeine	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Tobacco/Vaping	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Alcohol	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Opioids/ Prescription Drugs	Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Marijuana	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Hallucinogens	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Amphetamines	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Other:	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never

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Family Medical History: __ N/A

Medical Condition	Patient or Family History	Please list the Family Member(s) affected
Anemia	☐ Patient ☐ Family History	
Asthma/Respiratory Concerns	☐ Patient ☐ Family History	
Cancer	☐ Patient ☐ Family History	
Chronic Fatigue	☐ Patient ☐ Family History	
Concussion(s) or TBI	☐ Patient ☐ Family 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 ☐ Family History	
Stroke	☐ Patient ☐ Family History	
Substance Abuse	☐ Patient ☐ Family History	
Thyroid Disease	☐ Patient ☐ Family History	

Psychiatric history: ☐ N/A

Psychiatric Condition	Patient or Family History	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 history or hospitalizations | N/A

Surgery/Reason for Hospitalization	Date(s)	Hospital	Doctor/Attending	Location (City, State)

Have you had any bloodwork completed within the last 6 months (if yes, who ordered the labs to be drawn): ☐ Yes ☐ No

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