Welcome to
New England Allergy, Asthma, Immunology, Pediatric and Primary Care, PLLC
Your family's home for primary and specialty care!

New Adult Primary Care Questionnaire

First and Last Name: _____ Date of Birth_____

Marital Status: Single Partnered Married Separated Divorced Widowed

Occupation: _____ Hobbies: _____

Prior/Referring Doctor_____ Date of last Physical Exam:_____

Personal Health History
Past or Present Medical History (circle all that apply to you)

Alcohol/Drug Problem	Emphysema/COPD	Liver Disease	Blood Clots
Anemia	Heart attack/MI	Osteoporosis	Peripheral Artery Disease
Anxiety	Coronary Artery Disease	Prostate problem	Neuropathy
Arthritis	Heart Failure, CHF	Depression	Sleep Apnea
Asthma	High blood pressure	Other psychiatric history:	Heart Murmur
Atrial Fibrillation	High cholesterol	Seizure Disorder	Migraines
Dementia	Low thyroid	Stroke	Hepatitis
Diabetes	High thyroid	Ulcers of the stomach	Diverticulosis
Cancer – type(s):	Kidney disease	STD/STI/sexual infection	Colon polyps
	Endometriosis	Abnormal pap test	Positive TB test
Other:			

When was your last episode of COVID-19, influenza, and/or RSV? _____
Did you have to go to the ER, or stay in the hospital? _____

Mammogram Date: _____ Normal/Abnormal Comments:_____
Colonoscopy Date: _____ Normal/Abnormal Comments:_____
Prostate Test Date: _____ Normal/Abnormal Comments: _____
Dental Exam Date: _____ Normal/Abnormal Comments: _____
Eye Exam Date: _____ Normal/Abnormal Comments: _____
Pap smear Date: _____ Normal/Abnormal Comments: _____
Bone Density Study Date: _____ Normal/Abnormal Comments: _____

For those who have/had a uterus:

At what age was your first period? _____

When was your last period?_____

Are they regular? Severe cramping? Heavy flow?_____

Any chance you could be pregnant now?_____ Have you been pregnant before? Yes/No # pregnancies:_____

Have you birthed any children? Yes/No #births:_____ Do you have any children? Yes/No # children:_____

When did you last see an OBGYN?_____

Have you gone through menopause? If so, when? _____

Any sexual health questions today?_____

Allergies

Please list the allergen as well as reaction, any treatment required

_____

_____

_____

Medications

Please list all prescribed and over-the-counter medications, vitamins, and supplements

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Immunizations

Please include approximate year or age of dose

Tetanus	Pneumonia/Pneumovax	Hepatitis A	COVID-19 Brand: Primary Series: Last Dose:
Influenza	Prevnar 13	Hepatitis B	
HPV	Shingles vaccine/Zostavax	RSV	

Questions about any vaccines today?_____

_____

Surgeries

Please include year or age at time of the surgery and if any complications arose

Appendectomy	Cataract Surgery Left Right	Vasectomy
Cardiac Bypass (CABG)	Tonsillectomy	Tubal ligation
Cardiac Stent/Angioplasty	Adenoidectomy	C-section (Cesarian delivery)
Gallbladder removal- laparoscopic	T-tubes	Hysterectomy - partial
Gallbladder removal- open	Prostate Surgery	Hysterectomy - total
Hernia Repair	Breast Surgery Left Right	Mohs/Skin Cancer Surgery
Orthopedic surgeries: (please list)		
Other surgeries:		

Any surgeries planned or intended? _____

_____

_____

What have you been to the Emergency Room for in the past year?_____

_____

_____

Have you ever been admitted to the hospital? When, for what, and for how long?

_____

_____

_____

Family Health History

Relative	Age (please indicate if living or deceased)	Medical conditions (Healthy; diabetes, high blood pressure, cholesterol, heart disease, cancer and type of cancer, stroke, psoriasis, thyroid disease, autoimmune conditions, etc)
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Sibling (Brother/Sister)		
Sibling (Brother/Sister)		
Sibling (Brother/Sister)		
Other relatives or unknown Exact relation:		

Health Habits and Personal Safety

Please circle all those that apply and write in detail as requested

Exercise Sedentary (no exercise)
Mild (climb stairs, walk 3 blocks, golf)
Occasional vigorous exercise (workout/recreation, 1-3x/week for 30min)
Regular vigorous exercise (workout/recreation, >3x/week for 30min)

Diet List meals in past 24 hrs:
Breakfast_____Lunch _____Dinner_____
Snacks_____
Beverages_____
Coffee/Caffeinated Drinks/Energy Drinks in past week: _____
Water oz per day_____

Alcohol Yes/No 0-1x/month 2-4x/month every week every day How many at a time? _____
Each week, how many: servings of Beer?____ Glasses of wine?____ Shots/mixed drinks?_____
When did you last have more than 4 drinks in one day? _____
Do you feel you should cut down on drinking? Yes/No
Do people annoy you by nagging you about your drinking? Yes/No
Have you ever felt guilty about your drinking? Yes/No
Have you ever had a morning drink to steady your nerves? Yes/No

Drugs Are you a current or former tobacco smoker? Yes/No
How many packs per day?_____ For how many years?_____
When did you quit, if you have? _____
Do you wish to discuss quitting the use of cigarettes? Yes/No Why?_____
Do you use marijuana? Method: _____ Frequency:_____
Do you feel you depend on the use of marijuana? Yes/No Why?_____
Do you juule, vape, or use e-cigarettes? Yes/No Contents:_____ Frequency:_____
Have you used recreational or street drugs within the past 2 years? Yes/No What:_____
Have you ever used recreational drugs with a needle? Yes/No What:_____
Do you feel you have a substance use or abuse problem? Yes/No Why:_____
Have you ever driven a vehicle while under the influence of drugs, including marijuana? Yes/No
Have you ever been driven by someone else under the influence of drugs, alcohol, or other substance? Yes/No

Personal Safety Do you wear seatbelts? Yes No Sometimes
Do you have frequent falls? Yes No Sometimes
Does your home have a working smoke detector? Yes/No
Does your home have a working carbon monoxide detector? Yes/No
Are there any firearms, guns, or other weapons at home? Yes/No
Do you wear sunscreen? Yes No Sometimes
Do you perform tick checks in the spring through fall? Yes No Sometimes
Do you experience conflicts in your relationships that take the form of verbally threatening behaviors, mental abuse, physical abuse, or sexual abuse?
Yes No Sometimes Unsure: _____

Sexual Health

Please circle answers as they relate to you.

Do you identify as: male female nonbinary other: _____?

Do you identify with the gender you were assigned at birth? Yes/No Preferred Pronouns: _____

If your preferred name/gender identity is different from what is medicolegally established, please note here your

preference of name/gender identity: _____

Are you attracted romantically/sexually to: males females nonbinary asexual pansexual bisexual unsure ?

Other: _____

Sexually Active? Yes/No Last encounter: this week this month past few months this year years ago

partners in the past year: _____

Types of sexual activity: oral vaginal anal other (please specify): _____

Any history of sexually transmitted infections ("STI"s)? Yes/No Type/date:_____

Did you undergo treatment?_____

Would you like to undergo testing for STIs today? This includes hepatitis, HIV, syphilis, gonorrhea/chlamydia, and antibodies to herpes simplex virus. Yes / No **please inform the medical provider of your request directly, as well**

Current contraception method(s): _____

Are you in a relationship? _____ Is this relationship: monogamous polygamous polyamorous open other ?

Do you feel safe in this relationship? Yes/No If no, please clarify: _____

Do you have any sexual health related questions or concerns today? If so, please specify:

_____

Please note: we will do our best to honor your requests re: pronouns/name use.
As we are all human, we appreciate your patience if the many intricacies of the medical system make this challenging to uphold 100% of the time.
Please know you are welcome here regardless of name, pronoun, identity, ethnicity, sexual orientation, race, weight, socioeconomic status, favorite color, podcast preference, hairstyle, tik-tok stream, or any other characteristic (silly or serious) not based in hate or aimed to cause harm to others, directly or indirectly.

Let's all just be kind to each other.

–Tiffany K Johnson, MD
Owner/CEO of NEAAIP&PC, PLLC