Health History Questionnaire:

Name_____ Date of birth:_____

Address:_____

Alternative phone number_____

Local phone number_____

Please describe what problem or concern brought you to our office today:

Personal Health History

Please check past or current problems or conditions

Condition		Condition	
Hypertension		Seizures	
High cholesterol		Headaches	
Diabetes		Stroke	
Heart attack or angina		Prostate problem	
Irregular heart rhythm		Breast problem	
Congestive heart failure		Urinary tract infections	
Asthma		Cancer (Please list type)	
Emphysema or chronic bronchi		Thyroid problem	
Pneumonia		Bleeding disorder	
Gastroesophageal reflux disease		Addiction Issues	
Stomach ulcer		Depression or anxiety	
Kidney problems		Mental Illness	
liver disease/hepatitis		Other (please describe)	
Colon cancer			
Bowel/digestive roblem			

Previous Surgical Procedures

Please check if you have had any of the following

Procedure	Year
Heart surge	
Carotid artery surgery	
Vascular surgery/ stent	
Abdominal aneurysm repair	
Hysterectomy	
Gallbladder removed	
Appendix removed	
Tonsillectomy	
Joint replacement	
Breast cancer surgery	
Prostate cancer surgery	
Hernia	
Pacemaker	
Other (please describe)	

Social History:

Please circle appropriate answers below and provide explanations where appropriate

Marital status: Single Married Divorced Widowed Life Partner

Education level: Did not Graduate High School Some College Bachelor's Degree Master's Degree or Higher

Occupation:

Occupational concerns: Stress Hazardous substances Heavy lifting

How stressful would you rate your current living situation? (Circle number)

No stress 0 1 2 3 4 5 6 7 8 9 10 Very Stressful

Are there financial concerns that affect your ability to seek healthcare? No Yes If yes, describe below

Are there any religious or cultural factors that you would like us to consider when planning your healthcare?

Hobbies:

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

Chest pain	Rectal bleeding	Eve pain	Nervousness
Shortness of breath	Black/tarry stools	Loss of vision	Pain in testicles
Wheezing	Weight loss	Double vision	Loss of libido
Cough	Weight gain	Memory loss	Impotence
Coughing up blood	Loss of appetite	Ringing in ears	Breast pain
Sore throat	Difficulty swallowing	Pain in ears	Breast discharge
Nasal congestion	Diarrhea	Nose bleeds	other (please describe below)
Irregular heartbeat	Constipation	Hoarseness	
Fast heartbeat	Painful urination	Easy bleeding	
High blood pressure	Blood in urine	Easy bruising	
Low blood pressure	Urine frequently	Rash	
Lightheadedness	Decrease in urine flow	Changes in mole	
Dizziness/fainting	Urine leakage	Sore that won't heal	
Abdominal pain	Headache	Fatigue/lethargy	
Heartburn	Weakness	Insomnia	
Indigestion	Loss of strength	Forgetfulness	
Ankle swelling	Balance problems	Depression	
Nausea	Pain, weakness, or numbness in		
Vomiting	Arms	Hips	Back
Vomiting blood	Legs	Neck	Shoulders
Change in bowel habits	Hands	Feet	

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			

Specifically have any of your relatives had the following conditions

Condition	Relative	Condition	Relative
Mental illness		Chemical dependency	
Celiac Disease		Diabetes	
Colon Cancer		Pancreatic Disease	
Colon Polyps		Ulcerative Coiitis/Crohn's	
Heart Disease		Female Cancer (Breast, Ovarian,Uterlne, or Endometrial)	

Allergies:

Please list any allergies to medications or foods

Medications:

Please list any medications that you take including over the counter medications, herbs, and supplements. Include dose and frequency

Health Maintenance:

Please check whether you have had the following preventive services and enter the year of the service

Immunizations			Year	Tests			Year
Tetanus vaccine /Tdao	Yes	No		Pap smear/pelvic	Yes	No	
Pneumonia vaccine	Yes	No		Mammogram	Yes	No	
Influenza vaccine	Yes	No		Bone dexa	Yes	No	
Shingles vaccine	Yes	No		Colonoscopy	Yes	No	
				Prostate test	Yes	No	

Specialty Providers:

In order that we c:an best coordinate your care, please list any medical providers you see outside of this practice and list the year that you last saw them

Eye doctor	Nephrologist
cardiologist	Psychiatrist
Oncologist	Allergist
Urologist/ Gynecologist	Vascular
Gastroenterologist	Pulmonologist
Endocrinologist	Other

Health Behaviors:

Tobacco use: Never Quit (when) Current smoker

If current smoker how many packs per day for how many years

Alcohol intake: No Yes If yes, more than 3 times per week?

Illicit drug use (including marijuana, cocaine, steroids): Never Past Current

If past or current drug use describe:

Exposure to secondhand smoke	Yes	No	Do you have any piercings?	Yes	No
Eat a diet high in fruits and vegetables	Yes	No	Do you have any tattoos?	Yes	No
Get 30 minutes of exercise 5 times a week	Yes	No	Have you traveled outside the US?	Yes	No

Advance Care Planning:		
Do currently have, or would you like information on, any of the following items		
Living Will: ·	Have ☐	Don't Have ☐
Durable Power of Attorney:	Have ☐	Don't Have ☐
DNR Order:	Have ☐	Don't Have ☐
Other:	Have ☐	Don't Have ☐

Urinary Incontinence Assessment				
In the past few weeks:				
Have you experienced leaking before an urgent need to urinate?	☐	☐	☐	☐
Have you experienced leaking on effort, such as when sneezing, coughing, jumping, laughing, or during physical activity?	☐	☐	☐	☐

Mood Screening	
A person's mood can have a strong influence on their health, status, and overall wellbeing. Over the past 2 weeks, how often have you been bothered by any of the following problems?	
Little interest or pleasure in doing things	Feeling down, depressed, or hopeless
Not at all ☐	Not at all ☐
Several days ☐	Several days ☐
More than half the days ☐	More than half the days ☐
Nearly every day ☐	Nearly every day ☐

Health Literacy Questionnaire	
Many times, in healthcare staff and providers use words that are unfamiliar to the general population. Please rate the. following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree	
I feel that I have a thorough understanding of the Instructions that my doctors and nurses give me about my health	1 2 3 4 5 6 7 8 9 10
I feel that I remember the instructions given to me at my doctor's office when I get home	1 2 3 4 5 6 7 **8** 9 10
I feel that I have a strong understanding of medical language	1 2 3 4 5 **6** 7 8 9 10

Patient Signature:_____ Date:_____