# 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:_____