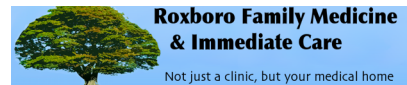


Health History Questionnaire:



Name _____ Date of birth _____

Address _____

Local phone number _____ Alternative phone number _____

Preferred Pharmacy _____ Pharmacy phone number _____

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

- Primarily to establish care
- Other (please briefly describe) _____

Special Communication Needs:

Language preference: _____

If 'yes' to any of the questions below, how can we assist?

Visual impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cognitive impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sensory impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Speech impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other:	_____	

Personal Health History

Please check past or current problems or conditions

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

Previous Surgical Procedures

Please check if you have had any of the following

Procedure	Year
<input type="checkbox"/> Heart surgery	
<input type="checkbox"/> Carotid artery surgery	
<input type="checkbox"/> Vascular surgery / stent	
<input type="checkbox"/> Abdominal aneurysm repair	
<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Gallbladder removed	
<input type="checkbox"/> Appendix removed	
<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Joint replacement	
<input type="checkbox"/> Breast cancer surgery	
<input type="checkbox"/> Prostate cancer surgery	
<input type="checkbox"/> Hernia	
<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> 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 take into account when planning your healthcare?

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

<input type="checkbox"/> Chest pain	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Black/tarry stools	<input type="checkbox"/> Loss of vision	<input type="checkbox"/> Pain in testicles
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Double vision	<input type="checkbox"/> Loss of libido
<input type="checkbox"/> Cough	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Impotence
<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Breast pain
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Pain in ears	<input type="checkbox"/> Breast discharge
<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Other (please describe below)
<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Constipation	<input type="checkbox"/> Hoarseness	
<input type="checkbox"/> Fast heartbeat	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Easy bleeding	
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Easy bruising	
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Urine frequency	<input type="checkbox"/> Rash	
<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Decrease in urine flow	<input type="checkbox"/> Changes in mole	Females - Please complete
<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> Urine leakage	<input type="checkbox"/> Sore that won't heal	Menstrual flow:
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Headache	<input type="checkbox"/> Fatigue/lethargy	<input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. <input type="checkbox"/> Pain/cramps
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Weakness	<input type="checkbox"/> Insomnia	Days of flow ___ Length of cycle ___
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Loss of strength	<input type="checkbox"/> Forgetfulness	1st day of last period _____
<input type="checkbox"/> Ankle swelling	<input type="checkbox"/> Balance problems	<input type="checkbox"/> Depression	<input type="checkbox"/> Pain or bleeding after sex
<input type="checkbox"/> Nausea	Pain, weakness, or numbness in		Number of pregnancies ___
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Arms	<input type="checkbox"/> Hips <input type="checkbox"/> Back	Miscarriages ___
<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Legs	<input type="checkbox"/> Neck Shoulders	Birth control method _____
<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Hands	<input type="checkbox"/> Feet Knees	

Family History

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

Specifically have any of your relatives had the following conditions

Condition	Relative	Condition	Relative
<input type="checkbox"/> Mental illness		<input type="checkbox"/> Chemical dependency	

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 / Tdap <input type="checkbox"/> Yes <input type="checkbox"/> No		Pap smear/pelvic <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pneumonia vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No		Mammogram <input type="checkbox"/> Yes <input type="checkbox"/> No	
Influenza vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No		Bone dexta <input type="checkbox"/> Yes <input type="checkbox"/> No	
Shingles vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No		Colonoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Prostate test <input type="checkbox"/> Yes <input type="checkbox"/> No	

Specialty Providers:

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

<input type="checkbox"/> Eye doctor	<input type="checkbox"/> Nephrologist
<input type="checkbox"/> Cardiologist	<input type="checkbox"/> Psychiatrist
<input type="checkbox"/> Oncologist	<input type="checkbox"/> Allergist
<input type="checkbox"/> Urologist / Gynecologist	<input type="checkbox"/> Vascular
<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> Pulmonologist
<input type="checkbox"/> Endocrinologist	<input type="checkbox"/> 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 how many drinks/how often _____

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

If past or current drug use describe:

Exposure to secondhand smoke <input type="checkbox"/> Yes <input type="checkbox"/> No	Wear a seatbelt <input type="checkbox"/> Yes <input type="checkbox"/> No
Eat a diet high in fruits and vegetables <input type="checkbox"/> Yes <input type="checkbox"/> No	See a dentist at least once a year <input type="checkbox"/> Yes <input type="checkbox"/> No
Get 30 minutes of exercise 5 times a week <input type="checkbox"/> Yes <input type="checkbox"/> No	Wear sunscreen <input type="checkbox"/> Yes <input type="checkbox"/> No

Advance Care Planning:

Do currently have, or would you like information on, any of the following items

Living Will:	<input type="checkbox"/> Have	<input type="checkbox"/> Don't Have	<input type="checkbox"/> Want Information
Durable Power of Attorney:	<input type="checkbox"/> Have	<input type="checkbox"/> Don't Have	<input type="checkbox"/> Want Information
DNR Order:	<input type="checkbox"/> Have	<input type="checkbox"/> Don't Have	<input type="checkbox"/> Want Information
Other:	<input type="checkbox"/> Have	<input type="checkbox"/> Don't Have	<input type="checkbox"/> Want Information

Urinary Incontinence Assessment

Do you experience urinary leaking in the following situations?

	Not at all	A little	Sometimes	A lot
During daily activities (work, household task)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During physical activities (walking, swimming, or other exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During recreational activities (movies, hobbies)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During social activities (going out with friends, family visits)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During car trips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fall Risk Screening

In the last 12 months have you fallen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure		
If yes, how many times?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5+
Were you injured as a result of this fall?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure		

Functional Assessment

Do you need assistance in the following areas?

	Not at all	A little	Sometimes	A lot
Bathing, dressing and grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daily activities (cooking, cleaning other household tasks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking or driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicating needs and feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keeping appointments, taking medications and performing other medical treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
<input type="checkbox"/> Not at all	<input type="checkbox"/> Not at all
<input type="checkbox"/> Several days	<input type="checkbox"/> Several days
<input type="checkbox"/> More than half the days	<input type="checkbox"/> More than half the days
<input type="checkbox"/> Nearly every day	<input type="checkbox"/> 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: _____