Masonboro Family Medicine

Health History Questionnaire:

Name_____ Date of birth_____

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: Requires Updating Annually If no changes please check No change box			
Language preference:			
If 'yes' to any of the questions below, how can we assist?			
Visual impairment	☐ Yes ☐ No	**Cognitive impairment**	☐ Yes ☐ No
Hearing impairment	☐ Yes ☐ No	**Sensory impairment**	☐ Yes ☐ No
Speech impairment	☐ Yes ☐ No	**Other:**	

Personal Health History		Previous Surgical Procedures	
Please check past or current problems or conditions		Please check if you have had any of the following	
Condition	**Condition**	**Procedure**	**Year**
☐ Hypertension	☐ Seizures	☐ Heart surgery	
☐ High cholesterol	☐ Headaches	☐ Carotid artery surgery	
☐ Diabetes	☐ Stroke	☐ Vascular surgery / stent	
☐ Heart attack or angina	☐ Prostate problem	☐ Abdominal aneurysm repair	
☐ Irregular heart rhythm	☐ Breast problem	☐ Hysterectomy	
☐ Congestive heart failure	☐ Urinary tract infections	☐ Gallbladder removed	
☐ Asthma	☐ Osteoarthritis	☐ Appendix removed	
☐ Emphysema or chronic bronchitis	☐ Cancer (Please list type)	☐ Tonsillectomy	
☐ Pneumonia	☐ Thyroid problem	☐ Joint replacement	
☐ Gastroesophageal reflux disease	☐ Bleeding disorder	☐ Breast cancer surgery	
☐ Stomach ulcer	☐ Addiction Issues	☐ Prostate cancer surgery	
☐ Kidney problems	☐ Depression or anxiety	☐ Hernia	
☐ Liver disease/hepatitis	☐ Mental Illness	☐ Pacemaker	
☐ Colon cancer	☐	☐ Other (please describe)	
☐ Bowel/digestive problem	Pain, weakness, numbness		
☐ No Change since Previous Year			

Family History			
Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			
			No Change since Previous year

Specifically have any of your relatives had the following conditions			
Condition	Relative	Condition	Relative
☐ Mental illness		☐ Chemical dependency	

ALLERGIES: Please list any allergies to medications or foods-**If no changes please indicate No changes from Previous Year**	

Specialty Providers: Requires Updating Annually	
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	
☐ **Eye doctor**	☐ **Nephrologist**
☐ **Cardiologist**	☐ **Psychiatrist**
☐ **Oncologist**	☐ **Allergist**
☐ **Urologist / Gynecologist**	☐ **Vascular**
☐ **Gastroenterologist**	☐ **Pulmonologist**
☐ **Endocrinologist**	☐ **Other**
☐ **No new specialist visits since previous year**	

Please list any medications prescribed by PCP or specialty Providers. Please include name, dose and frequency	

It is very important that you take the medication(s) your health care professional has given you. Please check any of the below

Are you unable to fill your prescription(s) because of the cost ☐ **Yes** ☐ **No**

Are you unable to fill your prescriptions because of lack of transportation ☐ **Yes** ☐ **No**

Have you ever applied for any pharmacy assistance ☐ **Yes** ☐ **No**

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**
Job concerns: ☐ **Stress** ☐ **Hazardous substances** ☐ **Heavy lifting** ☐ **Transportation**
How stressful would you rate your current living situation: (Circle number) **Not Very Stressful 0 1 2 3 4 5 6 7 8 9 10 Very Stressful** **Do you fear for your safety in your current living situation?** ☐ **No** ☐ **Yes If yes, describe below**
Are there financial concerns that affect your ability: 1) to go to the doctor ☐ **No** ☐ **Yes** **If yes, describe: _____** **2) to obtain food and shelter** ☐ **No** ☐ **Yes If yes, describe: _____**
Are there any religious or cultural Living factors that you would like us to take into account when planning your healthcare? ☐ **No** ☐ **Yes If yes, describe:** **Do you currently have or would you like information on any of the following items:** **Living Will Information:** ☐ **Have** ☐ **Don't Have** ☐ **Want** **Durable Power of Attorney:** ☐ **Have** ☐ **Don't Have** ☐ **Want** **DNR Order:** ☐ **Have** ☐ **Don't Have** ☐ **Want**

Health Literacy Questionnaire	
It is really important to your provider that you understand the information related to your health. 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

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

Immunizations			Year	Tests			Year
Tetanus vaccine / Tdap	☐ Yes	☐ No		Pap smear/pelvic	☐ Yes	☐ No	
Pneumonia vaccine	☐ Yes	☐ No		Mammogram	☐ Yes	☐ No	
Influenza vaccine	☐ Yes	☐ No		Bone dexascan	☐ Yes	☐ No	
Shingles vaccine	☐ Yes	☐ No		Colonoscopy	☐ Yes	☐ No	
				Prostate test	☐ Yes	☐ No	
Additional Vaccines taken since previous year		☐ Yes		☐ No If yes, list vaccine name and date			

Mood Screening: Requires Updating Annually for age 11 and up	
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 Behaviors: Requires Updating Annually for 11 years and older				
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	☐ Yes	☐ No	Wear a seatbelt	☐ Yes ☐ No
Eat a diet high in fruits and vegetables	☐ Yes	☐ No	See a dentist at least once a year	☐ Yes ☐ No
Get 30 minutes of exercise 5 times a week	☐ Yes	☐ No	Wear sunscreen	☐ Yes ☐ No

Urinary Incontinence Assessment: Requires Updating Annually for 65 years and older				
Do you experience leaking in the following situations:	Not at all	A little	Sometimes	A lot
During daily activities (work, household task)	☐	☐	☐	☐
During physical activities (walking, swimming, or other exercise)	☐	☐	☐	☐
During recreational activities (movies, hobbies)	☐	☐	☐	☐
During social activities (going out with friends, family visits)	☐	☐	☐	☐
During car trips	☐	☐	☐	☐

Fall Risk Screening: Requires Updating Annually for 65 years and older	
In the last 12 months have you fallen?	☐ Yes ☐ No ☐ Unsure
If yes, how many times?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
Were you injured as a result of this fall?	☐ Yes ☐ No ☐ Unsure

Functional Assessment: Requires Updating Annually for 65 years and older				
Do you need assistance in the following areas?	Not at all	A little	Sometimes	A lot
Bathing, dressing and grooming	☐	☐	☐	☐
Daily activities (cooking, cleaning other household tasks)	☐	☐	☐	☐
Walking or driving	☐	☐	☐	☐
Communicating needs and feelings	☐	☐	☐	☐
Understanding directions	☐	☐	☐	☐
Keeping appointments, taking medications and performing other medical treatments	☐	☐	☐	☐
If yes to any of these questions, who helps with these activities?				

Opioid History and Current Usage:

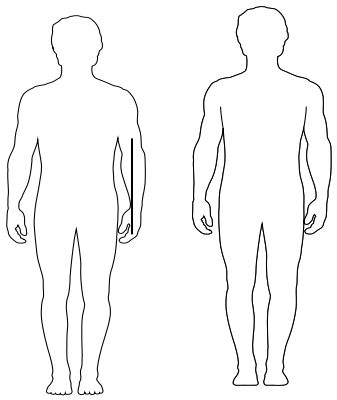
It is very important that you take the medication(s) your health care professional has given you. Please check any of the below

Have you ever taken drugs called Opioids (Ex: morphine, oxycontin, dilaudid, fentanyl)?	Yes	No
Are you currently taking an Opioid for chronic pain?	Yes	No
Did you utilize non-medication treatments for your pain before taking medication? (Heat/Cold/Physical Therapy/)	Yes	No

Patient Signature: _____ Date:_____

Provider reviewed: _____ Date:_____

Pain Questionnaire



1. Where is your pain? Write in words or use the picture to show where you have pain.
   _____

2. Circle the words that describe your pain.

   Aching Throbbing Shooting Stabbing Gnawing Tender Burning Exhausting Nagging Numb

3. *Does your pain occur occasionally, frequently or is it constant? (Circle one)*

   Occasionally Frequently Constant

4. *What time of day is your pain the worst? (Circle one)*

   Morning Afternoon Evening Nighttime

5. *Rate your pain by circling the number that best describes your pain at its **worst** in the last month.*

   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

6. *Rate your pain by circling the number that best describes your pain at its **least** in the last month.*

   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

7. Rat*e your pain by circling the number that best describes your pain on **average** in the last month.*

   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

8. *Rate your pain by circling the number that best describes your pain **right now**.*

   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

9. *What makes your pain **better***? _____

10. *What makes your pain **worse***? _____

11. *What treatment or medication are you receiving for your pain? If you are not receiving any treatment or medication, circle NONE.*
    None
    _____

12. *Circle the one number that describes how, during the past week, pain has interfered with your*:

    a. General Activity Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

    b. Mood Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

    c. Normal Work Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

    d. Sleep Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

    e. Enjoyment of life Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

    f. Ability to concentrate Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

    g. Relationships with other people Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

☐ No action plan required ☐ Action plan required. See progress note.

Patient Signature: _____ Date:_____

Provider reviewed: _____ Date:_____