Health History Questionnaire:

Name_____ Date of birth_____

Address_____

Local phone number_____ Alternative 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	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)	Other (please describe)	
Bowel/digestive problem			

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			
Chest pain	Rectal bleeding	Eye 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 frequency	Rash	
Lightheadedness	Decrease in urine flow	Changes in mole	**Females - Please complete**
Dizziness/fainting	Urine leakage	Sore that won't heal	Menstrual flow:
Abdominal pain	Headache	Fatigue/lethargy	Reg. Irreg. Pain/cramps
Heartburn	Weakness	Insomnia	Days of flow __ Length of cycle__
Indigestion	Loss of strength	Forgetfulness	1st day of last period_____
Ankle swelling	Balance problems	Depression	Pain or bleeding after sex
Nausea	Pain, weakness, or numbness in		Number of pregnancies ___
Vomiting	Arms Hips Back		Miscarriages___
Vomiting blood	Legs Neck Shoulders		Birth control method _____
Change in bowel habits	Hands Feet		

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
Mental illness			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	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 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

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	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

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

Urinary Incontinence Assessment

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	☐	☐	☐	☐

In the Past few Weeks:

Have you frequently experienced the need to urinate?	☐	☐	☐	☐
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?	☐	☐	☐	☐
Have you experienced a pressing or immediate urge to urinate?	☐	☐	☐	☐
Have you noticed a change in your urination frequency?	☐	☐	☐	☐
Do you need to urinate more than 8 times every 24 hours?	☐	☐	☐	☐
Do you have to get up more than twice during the night to urinate?	☐	☐	☐	☐
Do you sometimes have to strain to urinate?	☐	☐	☐	☐

Fall Risk Screening	
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

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:_____