Health History Questionnaire:

MASONBORO FAMILY MEDICINE

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

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