Health History Questionnaire

Logo here

☐ Initial ☐ Annual

Name_____ Date of birth_____

Address_____

Local phone number_____ Alternative phone number_____

Special Communication Needs: Requires Updating Annually			
Language preference:			
If 'yes' to any of the questions below, how can we assist?			
Hearing impairment	☐ Yes ☐ No	**Cognitive impairment**	☐ Yes ☐ No
Speech impairment	☐ Yes ☐ No	**Sensory impairment**	☐ Yes ☐ No
Visual impairment	☐ Yes ☐ No	**Other:**	

Family History ☐ No change since previous year

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

Specifically have any of your relatives had the following conditions

Condition	Relative
☐ Mental Illness	
☐ Chemical Dependency	
☐ Opioid Dependency	

Personal Health History

No Change Since Previous Year ☐

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	☐ Osteoarthritis
☐ Emphysema or chronic bronchitis	☐ Cancer (Please list type)
☐ Pneumonia	☐ Thyroid problem
☐ Gastroesophageal reflux disease	☐ Bleeding disorder
☐ Stomach ulcer	☐ Addiction Issues
☐ Kidney problems	☐ Depression or anxiety
☐ Liver disease/hepatitis	☐ Mental Illness
☐ Colon cancer	☐ Other (please describe)
☐ Bowel/digestive problem	

Previous Surgical Procedures

No Change Since Previous Year ☐

Please check if you have had any of the following

Procedure	Year
☐ Heart surgery	
☐ 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)	

Specialty Providers: Requires Updating Annually	
In order to 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 last year	

Please list any new medications prescribed by specialists or providers other than your PCP. 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

Opioid History and Current Usage: Requires Updating Annually

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

Allergies	
Please list any allergies to medications or food, including food sensitivities	

Social History: Initial

Please check 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: (Check 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 factors that you would like us to take into account when planning your healthcare?

☐ No ☐ Yes **If yes, describe:**

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		

Patient Signature:_____ Date:_____

Provider Reviewed:_____ Date:_____

Preventive Health Screening

☐ Initial ☐ Annual

Name_____ Date Completed _____

Address_____

Local phone number_____ Alternative phone number_____

Preferred Pharmacy_____ Pharmacy phone number_____

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

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	☐0 ☐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	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
I feel that I have a strong understanding of medical language	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

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 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:		

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_____							
Have you or are you currently taking an Opioid medication smoke (ex: morphine, oxycontin, dilaudid, fentanyl)?				☐ Yes ☐ No			
If yes, Did you utilize non-medication treatments for your smoke pain before taking medication? (Heat/Cold/Physical Therapy)				☐ Yes ☐ No			
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)	☐	☐	☐	☐

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?				

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

Social History: Requires Updating Annually

Please check appropriate answers below and provide explanations where appropriate

Job concerns: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting ☐ Transportation

How stressful would you rate your job situation?

Not Very Stressful ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Very Stressful

Have you had CHANGE in Marital Status: ☐ No ☐ Yes If yes, describe below:

How stressful would you rate your current living situation?

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 factors that you would like us to take into account when planning your healthcare?

☐ No ☐ Yes If yes, describe:

Patient Signature:_____ Date:_____

Provider reviewed:_____ Date:_____