

## 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	<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		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
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Seizures	<input type="checkbox"/> Heart surgery	
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Headaches	<input type="checkbox"/> Carotid artery surgery	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Vascular surgery / stent	
<input type="checkbox"/> Heart attack or angina	<input type="checkbox"/> Prostate problem	<input type="checkbox"/> Abdominal aneurysm repair	
<input type="checkbox"/> Irregular heart rhythm	<input type="checkbox"/> Breast problem	<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Urinary tract infections	<input type="checkbox"/> Gallbladder removed	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Appendix removed	
<input type="checkbox"/> Emphysema or chronic bronchitis	<input type="checkbox"/> Cancer (Please list type)	<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Thyroid problem	<input type="checkbox"/> Joint replacement	
<input type="checkbox"/> Gastroesophageal reflux disease	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Breast cancer surgery	
<input type="checkbox"/> Stomach ulcer	<input type="checkbox"/> Addiction Issues	<input type="checkbox"/> Prostate cancer surgery	
<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Depression or anxiety	<input type="checkbox"/> Hernia	
<input type="checkbox"/> Liver disease/hepatitis	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Colon cancer	<input type="checkbox"/> Other (please describe)	<input type="checkbox"/> Other (please describe)	
<input type="checkbox"/> Bowel/digestive problem			

Social History:
Please circle appropriate answers below and provide explanations where appropriate
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Life Partner
Education level: <input type="checkbox"/> Did not Graduate <input type="checkbox"/> High School <input type="checkbox"/> Some College <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree or Higher
Occupation: Occupational concerns: <input type="checkbox"/> Stress <input type="checkbox"/> Hazardous substances <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> 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	<b>Females - Please complete</b>
<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 <input type="checkbox"/> Shoulders	Birth control method _____
<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Hands	<input type="checkbox"/> 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
<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 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"/>

### **In the Past few Weeks:**

Have you frequently experienced the need to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced leaking before an urgent need to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced leaking on effort, such as when sneezing, coughing, jumping, laughing, or during physical activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced a pressing or immediate urge to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed a change in your urination frequency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you need to urinate more than 8 times every 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have to get up more than twice during the night to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you sometimes have to strain to urinate?	<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		

### **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: \_\_\_\_\_