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| **Masonboro Family Medicine**  **Health History Questionnaire:** | | | | |
| Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| 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** | | | |
| **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:** | | |

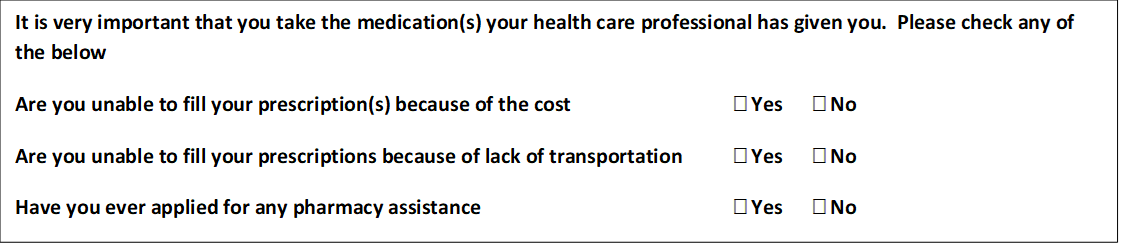
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| **Personal Health History** | | |  | **Previous Surgical Procedures** | |
| **Please check past or current problems or conditions** | | | **Please check if you have had any of the following** | |
| **Condition** |  | **Condition** | **Procedure** | **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** | | | | | |

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| **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 |  |

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| **ALLERGIES**: Please list any allergies to medications or foods | |
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| Please list any medications prescribed by PCP or specialty Providers. Please include name, dose and frequency | |
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| **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** |
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| **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** |

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| **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** |

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| **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** |  |
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| **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** |
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| **Health Behaviors: Requires Updating Annually for 11 years and older** | | | |
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| **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** | | |

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| **Urinary Incontinence Assessment: Requires Updating Annually for 65 years and older** | |
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| **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** | **□ □ □ □** |

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| **Fall Risk Screening: Requires Updating Annually for 65 years and older** | |
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| **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** |

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| **Functional Assessment: Requires Updating Annually for 65 years and older** | |
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| **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?** |  |

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider reviewed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_