Health History Questionnaire:

☐ **Initial** ☐ **Annual**

Name_____ Date of birth_____

Address_____

Local phone number_____ Alternative phone number_____

Gender at Birth: ___Male ___Female

Race: ___African American ___ Caucasian ___ Native American ____ Asian _____ Other_____

Ethnicity: ___ Hispanic/Latino ___ Not Hispanic/Latino _____ Other_____

Identify As: ___ Male ___Female ____Male to Female Transgender ___Female to Male Transgender ___Non-Conforming Gender

Sexual Orientation: ___ Asexual ___Homosexual ___Heterosexual ___ Bisexual ___ Other ___

Special Communication Needs: Requires Updating Annually **No Change from Previous year**

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

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	
		☐ Opioid dependency	

Personal Health History		**Previous Surgical Procedures**	
No Change Since Previous Year ☐		**No Change Since Previous Year ☐**	
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			

Specialty Providers: Requires Updating Annually	
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
☐ No new specialist visits since previous year	

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:

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 foods	

Social History: Annually

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**

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 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		

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

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 (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 circle appropriate answers below and provide explanations where appropriate

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

How stressful would you rate your job situation: (Circle number)

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 consider when planning your healthcare? ☐ No ☐ Yes **If yes, describe:**

Advance Care Planning:	
Do currently have, or would you like information on, any of the following items	
Living Will:	**/ Yes / No**
Durable Power of Attorney:	**/ Yes / No**
DNR Order:	**/ Yes / No**
Other:	

Patient Signature: _____ Date:_____

Provider Reviewed: _____ Date:_____