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Health History Questionnaire

Patient Name& Address

Name: ____ Date of Birth: _________________
Address: __________________________________ City: ____________________ State/Zip:_________
Phone Number: ___________________________ Social Security Number: ___________________________
Email:_____________________________________
Marital Status:

☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never married
Spouse's Name: __________________________ Spouse's Contact Number:___________________________

Race:

☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan
☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ I decline to Specify

Ethnicity:

☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ I decline to specify

Language – please fill in below:

Primary Language (the language you'd like us to use when we communicate with you):________________
Secondary Language: ____

Insurance Information

Insurance Name	Subscriber	Relationship to subscriber	Member ID	Copay

Responsible Party (Send Bills to)

Name: ______________________________ Home/Cell number: ______________________Work:______________
Address: ____________________________________ City: _______________________ State/Zip:______________

Please Indicate if Power of Attorney ☐ Yes ☐ No

Please Indicate if Responsible Party will access Patient Portal: ☐ Yes ☐ No If yes, Date of Birth__________

Contact in Case of Emergency

Name	Relationship	Address, City, State, Zip	Home/Cell Phone	Primary or Secondary Contact

Social History
Place of Birth: ____
Highest education level: ____
Occupation prior to retirement: ____
Place of residence prior to current: ______________________________________
Religious Preference: ____

Family History
Mother age of death ________________________________
Mother cause of death ________________________________
Father age of death ________________________________
Father cause of death ________________________________

Siblings:

☐ No ☐ Yes

Name of Sibling	Age of Sibling	Address	**If deceased**, Age at death	**If deceased**, Cause of death

Children:

☐ Yes ☐ No

Name of Child	Age of Child	Address	**If deceased**, Age at death	**If deceased**, Cause of death

Health Habits

Smoking history

☐ Non-Smoker

☐ Ex-smoker Year Quit ____________________________
Number of Packs Smoked Per Day ____________________________

☐ Smoker Number of Packs Smoked Per Day ____________________________
Number of years smoking ______________

Alcohol consumption history

☐ Never consumed

☐ Yes, I consume Amount of alcohol consumed per week _________________________

History of alcohol problem

☐ No

☐ Yes If yes, is this still an active problem ☐ No ☐ Yes

Immunization history

Do you receive a flu shot every year ☐ No
☐ Yes Year of last Flu shot _______________

Have you ever received vaccination for Pneumonia?

☐ No

☐ Yes Year of Pneumonia vaccination ___________________

Have you ever received a tetanus shot?

No

☐ Yes Year of Tetanus vaccination ___________________

Have you ever been tested for Tuberculosis?

☐ No ☐ Yes If yes, when and what were the results ____________________________________

Have you ever had Tuberculosis?

☐ No ☐ Yes If yes, were you treated ____

Have you ever been around anyone with TB?

☐ No ☐ Yes

Current Health

Describe general health compared to others the same age: ☐excellent ☐good ☐ fair ☐poor

Have you fallen within the past year: ☐ Yes ☐ No

Have you recently (within the last year) lost interest or pleasure in doing activities: ☐Yes ☐ No

Have you recently (within the last year) felt down, depressed and/or hopeless: ☐ Yes ☐ No

General health over the past 5 years: ____

____

Weight: changes in past 6 month's _______________ past year__________________________

Describe typical day/hobbies: ____

Activities of Daily Living

Are you able to?
(I = independently, A = with assistance, D = dependent on others for help)

Get dressed	☐I ☐A ☐D
Drive	☐I ☐A ☐D
Baths	☐I ☐A ☐D
Use Phone	☐I ☐A ☐D
Use toilet	☐I ☐A ☐D
Manage Money	☐I ☐A ☐D
Eat	☐I ☐A ☐D
Prepare Meals	☐I ☐A ☐D
Walk	☐I ☐A ☐D

Telephone ☐I ☐A ☐D

Getting up from Chair ☐I ☐A ☐D

Shop ☐I ☐A ☐D

Do you use? ☐ Walker ☐Cane ☐Commode ☐Raised toilet seat ☐ Hospital bed ☐ Wheelchair
Other assistive devices:

Past Medical History – Please check all the apply

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Emphysema
- ☐ Depression
- ☐ Anxiety
- ☐ Gout
- ☐ Osteoporosis
- ☐ Stomach Ulcers
- ☐ Kidney Stones
- ☐ Stroke
- ☐ Seizures
- ☐ Blood Clot in Legs or Lung
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Cancer
- ☐ Kidney Failure
- ☐ Recurrent Bladder Infections
- ☐ History of Psychiatric Care of Hospitalization
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis

Surgery

Please list all surgeries and date of surgery

Type of Surgery	Date

Health Maintenance

Date of last mammogram ________________________________

Do you want to continue with yearly mammograms ☐ Yes ☐ No

Date of last Pap smear ________________________________

Have you ever had a colonoscopy?

☐ No ☐ Yes If yes, year and results ____

Hospitalizations

Please list any hospitalizations over the past 5 years

Date of Hospitalization	Reason

Medications: PLEASE BRING ALL PILL BOTTLES TO YOUR FIRST APPOINTMENT.

Name of Medicine	Strength of Pill	Number of Pills	Number of Times per Day
Example: Norvasc	*5 mg*	*2 tablets*	*2 times a day*

Pharmacy Information

Pharmacy Currently Using: ________________________________

Address: ____

Phone & fax: ____

Allergies

List ALL allergies to medications and food along with reaction:

Allergic to:	Reaction

Are you allergic to Latex?

☐ No

☐ Yes If yes, what is reaction?____

Advanced Directive

Do you have a Health Care Proxy? ☐ No ☐ Yes

Do you have a Living Will? ☐ No ☐ Yes

Do you have a MOLST? ☐ No ☐ Yes

Please provide copies of the above documents if available

Person completing this form

Name: ______________________________ Relationship to Patient: ________________________

Signature: _______________________________ Date: ______________________________