Health Information Questionnaire

This is a confidential record of your medical history and will be kept in the office. Information contained here will not be released to any person unless you have authorized us to do so.

Name: _____ Date: ___/___/___

DOB: _____ Age: _____ ❑ New patient ❑ Established patient

What medical/health concerns bring you to our office today? _____

_____

Medical History

Have you ever had or been diagnosed to have (check all that apply):

❑ Alzheimer's disease
❑ Anemia
❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Atrial fibrillation
❑ Bleeding disorder
❑ Blood transfusion
❑ Cancer: What kind?
_____
❑ Cataracts
❑ Chicken pox
❑ Colon polyps
❑ Depression
❑ Diabetes/prediabetes
❑ Fracture
❑ Glaucoma
❑ Heart attack
❑ Heart disease
❑ Heart failure
❑ Heart murmur
❑ Heartburn
❑ Hemorrhoids
❑ High blood pressure
❑ High cholesterol
❑ Irritable bowel syndrome
❑ Jaundice/liver disease
❑ Kidney disease
❑ Migraines/headache
❑ Osteopenia
❑ Osteoporosis
❑ Pneumonia
❑ Prostate problems
❑ Rheumatic fever
❑ Seizures/epilepsy
❑ Stroke
❑ Syphilis
❑ TB/lung disease
❑ Thyroid disease
❑ Ulcers
❑ Urinary incontinence
❑ Other: _____

OB/GYN History (females only):

Age of menses: _____ Age of menopause: _____ Method of birth control: _____

How many pregnancies: _____ How many children: _____Vaginal or C-section _____

Hospitalizations and Surgeries

List any hospitalizations, surgeries or procedures you have had performed.

What	Date	What	Date

Specialists

List any other doctors involved in your care.

Name	Specialty

BayCare Medical Group

Health Information Questionnaire

Medications

List all medications you take on regular basis (include over-the-counter, herbal or natural remedies).

Medication Name	Strength	Daily Frequency	Medication Name	Strength	Daily Frequency

Allergies

Are you allergic to any medications? ❑ Yes ❑ No

If yes, please list: _____

Health Maintenance

If you've had a test or vaccine done, list when last performed:

❑ Bone density test: _____
❑ Cholesterol screen: _____
❑ Colonoscopy: _____
❑ Diabetes screen: _____
❑ Eye exam: _____
❑ Flu vaccine: _____
❑ Hep A vaccine: _____
❑ Hep B vaccine: _____
❑ HIV testing: _____
❑ HPV vaccine: _____
❑ Mammogram (females only): _____
❑ Meningococcal vaccine: _____
❑ Pap smear (females only): _____
❑ Pneumonia vaccine: _____
❑ Shingles vaccine: _____
❑ Tetanus vaccine: _____

Family History

Please indicate if your blood relative(s) have had/currently have the following by placing an X in appropriate column:

Family Member	Alcoholism	Mental Health Issues	Heart Attack/Disease	High cholesterol	High Blood Pressure	Diabetes	Thyroid Disease	History of Bowel Problems	Allergies	Osteoporosis	Alzheimer's Disease	Seizure	Stroke	Cancer (what kind)	Other
Mother (age __)															
Father (age __)															
Brother(s) (age __)															
Sister(s) (age __)															
Grandparents															
Biological children															
Other: _____															

New Patient Health Questionnaire

Social History

Do you drink alcohol? ❑ Yes ❑ No

If you answered yes, answer these additional questions:

- What type of alcohol? _____
- How frequently? _____
- How many drinks does it take to get you high? _____
- Have people annoyed you by criticizing your drinking? ❑ Yes ❑ No
- Have you ever felt you should cut down on your drinking? ❑ Yes ❑ No
- Have you ever had a drink first thing in the morning to steady your nerves? ❑ Yes ❑ No
- Have you ever had a substance abuse problem? ❑ Yes ❑ No

If you answered yes, answer these additional questions:

- What type of drugs do you use? _____
- How frequently? _____

Have you ever smoked? ❑ Yes ❑ No

If you answered yes, answer these additional questions:

- Do you still smoke? ❑ Yes ❑ No
- How many cigarettes/day? _____
- How many years have you smoked? _____
- If you recently stopped smoking, when did you quit? _____

Occupation: _____ ❑ Full-time ❑ Part-time

If retired, what was your former occupation: _____

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other: _____

Education through grade: _____

Do you regularly exercise? ❑ Yes ❑ No

What type of exercise (e.g. biking, walking, running, swimming, etc.)? _____ How often? _____

Number of children: _____ Number of persons in household: _____

What type of living arrangement: ❑ House ❑ Apartment ❑ Condo ❑ Dorm ❑ Other: _____

Do you feel safe in your home environment? ❑ Yes ❑ No

Do you eat a healthy diet? ❑ Yes ❑ No

Are you on a special diet? ❑ Yes ❑ No

Do you use caffeine on regular basis? ❑ Yes ❑ No

Do you have any sleeping problems? ❑ Yes ❑ No

Do you have a high level of stress in your life? ❑ Yes ❑ No

Do you lack interest or pleasure in doing things you used to do? ❑ Yes ❑ No

Are you sexually active? ❑ Yes ❑ No

First active at age: _____ Current # of partners: _____ Number of life partners: _____

Self-described orientation: _____

Use of contraception: ❑ Condoms ❑ Birth control ❑ Other: _____

New Patient Health Questionnaire

General Information

Who completed this health form? _____

What is your preferred language for health care information? _____

What is the best way for the office to contact you? ❑ Phone ❑ Email ❑ Other: _____

Are you disabled? ❑ Yes ❑ No

If yes, what is the nature of your disability?_____

Do you have a living will or an advance directive? ❑ Yes ❑ No

If yes, what type? _____

If you experienced any of these issues in the last 10 days, place a check mark next to the symptom.

General
- ❑ Recent fever
- ❑ Excessive fatigue
- ❑ Unexplained weight loss/gain

Eyes
- ❑ Discharge
- ❑ Pain or burning
- ❑ Blurred vision
- ❑ Loss of sight
- ❑ Itching or watering

Breast
- ❑ Pain
- ❑ Lumps
- ❑ Nipple discharge

Respiratory
- ❑ Cough
- ❑ Coughing up blood
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Snoring

Reproductive - Women
- ❑ Irregular periods
- ❑ Spotting between periods
- ❑ Vaginal discharge/ burning/itching
- ❑ Unusually painful periods
- ❑ Pain/trouble during intercourse

Reproductive - Men
- ❑ Discharge from penis
- ❑ Pain or swelling of testicles
- ❑ Pain/trouble during intercourse
- ❑ Problems with erection

Mental Health
- ❑ Thoughts of suicide
- ❑ Marital problems
- ❑ Trouble sleeping
- ❑ Panic attacks
- ❑ Anxiety
- ❑ Thoughts of harming others

Skin
- ❑ Change in nails
- ❑ Lumps
- ❑ Recurrent rashes
- ❑ Sores that will not heal or that bleed
- ❑ Moles that are changing

Ears
- ❑ Hearing loss
- ❑ Ringing
- ❑ Earache
- ❑ Feeling of ear fullness

Mouth and Throat
- ❑ Dry mouth
- ❑ Soreness or bleeding in mouth area
- ❑ Sore throat
- ❑ Mouth ulcers
- ❑ Hoarseness
- ❑ Dental issues

Endocrine
- ❑ Unusual intolerance of heat
- ❑ Unusual intolerance of cold
- ❑ Excessive thirst
- ❑ Excessive hunger

Urinary
- ❑ Pain/burning with urination
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Trouble starting to urinate
- ❑ Waking up to urinate
- ❑ Leakage of urine
- ❑ Change in stream

Nervous System
- ❑ Headaches
- ❑ Seizures/convulsions
- ❑ Fainting spells
- ❑ Frequent memory loss
- ❑ Weakness
- ❑ Shakiness or tremor
- ❑ Loss of sensation/numbness
- ❑ Feeling of tingling in limb
- ❑ Speech difficulty

Nose and Sinuses
- ❑ Bleeding
- ❑ Nasal congestion
- ❑ Sneezing
- ❑ Loss of sense of smell

Neck
- ❑ Pain
- ❑ Lumps

Cardiovascular
- ❑ Abnormal/irregular heart beat
- ❑ Chest pain
- ❑ Awaken at night with breathing problems
- ❑ Passing out
- ❑ Shortness of breath
- ❑ Swelling of ankles
- ❑ Leg pain/resting
- ❑ Leg pain/walking

Gastrointestinal
- ❑ Unable to eat certain foods
- ❑ Loss of appetite/weight
- ❑ Food sticks in throat
- ❑ Painful swallowing
- ❑ Heartburn
- ❑ Indigestion
- ❑ Nausea
- ❑ Vomiting blood
- ❑ Abdominal or stomach pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Recent change in bowel habits
- ❑ Blood in stools
- ❑ Black stools

Musculoskeletal
- ❑ Joint pain
- ❑ Joint stiffness
- ❑ Muscle soreness

Blood Disorders
- ❑ Easy bruising
- ❑ Excessive bleeding