MEDICAL HISTORY SCREENING QUESTIONNAIRE

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This is your medical history and screening form, to be completed prior to your first visit. All information will be kept confidential. This information will be used for the evaluation and management of your overall health. The form is extensive, but please try to make it as accurate and complete as possible. Please take your time and complete it carefully and thoroughly in the comfort of your home, and then review it to be certain you have not left anything out. Your answers will help us design a comprehensive plan of care that meets your individual needs.

If you have questions or concerns, we are here to help you complete this form to its entirety, but **you must make sure to arrive 30 minutes prior to your appointment time**. We realize that some parts of the form will be unclear to you. Do your best to complete the form. Your questions will be thoroughly addressed afterwards. It might be helpful for you to keep a written list of questions or concerns as you complete the following medical history and screening form.

By signing below, you acknowledge by filling out this form the information given is true and accurate. You also agree with the above written statement and that you have reviewed the HIPAA Notice of Privacy. A written copy can be provided at your request.

Date:_____

Print Name:_____

Signature: _____

GENERAL INFORMATION

Demographic information

Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth ____/____/_____ Email: _____@_____

How did you hear about us? _____

Phone number: Cell _____ - _____ - _____ ; Home _____-_____-_____

Emergency contact name & phone #_____

Ethnicity (please circle)

Not Hispanic or Latino Hispanic or Latino Unknown or Declined

Race (please circle)

White American Indian or Alaska Native Asian Black/African American

Native Hawaiian/other Pacific Island Other Race

Reason(s) for Your Visit (Check all that apply)

- ☐ General wellness examination and disease prevention
- ☐ Acute Care Assessment & Management
- ☐ Chronic Disease Management
- ☐ Psychological Concerns
- ☐ Sexual Concerns
- ☐ Aesthetic Services
    - If so, please explain which services are you interesting in?
      _____
      _____
      _____
- ☐ Other (please explain) _____

Please List Prior Family Physician and/or Health Care Provider Specialists:

Provider's Name:_____

Specialty: _____

City: _____

Phone #_____

Provider's Name:_____

Specialty: _____

Phone #_____

City: _____

Provider's Name:_____

Specialty: _____

Phone #_____

City: _____

Provider's Name_____

Specialty: _____

Phone #_____

City: _____

May we request a copy of your health history records from your prior physician or primary health care provider?

□Yes, please complete the release form □No

May we pull your medication history electronically via Surescripts?

□Yes □No

SOCIAL HISTORY

Employment status

☐ Full Time ☐ Retired ☐ Disabled

☐ Part time ☐ Student ☐ Unemployed

Education

☐Grade School ☐Jr. High School ☐ High School

☐College (2-4 years) ☐Graduate School ☐ Degree _____

Smoking status

Have you ever smoked cigarettes, cigars or a pipe?

☐ Yes ☐ No (If no, skip to alcohol section)

If you did or now smoke cigarettes, how many per day? _____ Age started _____

If you did or now smoke cigars, how many per day? _____ Age started _____

If you did or now smoke a pipe, how many pipefuls a day? _____ Age started _____

If you have stopped smoking, when was it? _____

If you now smoke, how long ago did you start? _____

Alcohol Consumption status

Do you ever drink alcoholic beverages?

☐ Yes ☐ No (if no, skip to diet section)

If yes, what is your approximate intake of these beverages?

Beer:

☐ None ☐Occasional ☐Often; If often, _____per week

Wine:

☐ None ☐Occasional ☐Often; If often, _____ per week

Hard Liquor:

☐ None ☐Occasional ☐Often; If often, _____per week

At any time in the past, were you a heavy drinker (consumption of six ounces of hard liquor per day or more)?

☐ Yes ☐ No

Diet Status

What do you consider a good weight for yourself? _____

What is the most you have ever weighed (including when pregnant)? _____

_____ How old were you? _____

My current weight is: _____

Number of meals you usually eat per day: _____

Number of times per week you usually consume the following:

Beef _____ Fish _____Poultry_____ Desserts_____

Pork _____ Fowl _____Fried Foods_____

Homogenized (whole) milk _____ ___Buttermilk _____

Skim (nonfat) milk _____ low-fat milk _____Coffee _____

Tea (iced or not) _____ Regular or diet sodas _____Water_____

Do you usually use oil or margarine in place of high cholesterol shortening or butter?

□ Yes □ No

Do you usually abstain from extra sugar usage?

□ Yes □ No

Do you usually add salt at the table?

□ Yes □ No

Do you eat differently on weekends as compared to weekdays?

□ Yes □ No

SEXUAL HISTORY

Sex at Birth:

□Male □Female

Relationship Status: (check all that apply)

□ Single □ Married □ Divorced □ Widowed

□ Domestic/life partner □ Multiple partners

□ In a relationship with a male partner □ In a relationship with a female partner

Relationship/sexual concerns:

Do you have any sexual problems such as: (check all that apply)

- ☐ Inability to penetrate
- ☐ Lack of arousal
- ☐ Pain with intercourse
- ☐ Lack of enjoyment
- ☐ Lack of interest

Feeling of fear, guilt, shame and inadequacy regarding personal relationships and/or sexuality?

- ☐ Yes
- ☐ No

Does any of the above negatively impact your interpersonal relationship?

- ☐ Yes
- ☐ No

Are you now or have you ever been a victim of domestic violence?

- ☐ Yes
- ☐ No

Does any of the above concerns lead to anxiety, depression or personal distress?

- ☐ Yes

PRESENT MEDICAL HISTORY

Allergies

List any DRUG related allergies: _____

List any NON-DRUG related allergies_____ _____

Preferred Pharmacy

Name _____ City_____

Phone _____

CURRENT MEDICATIONS

Prescription Medication List (Attach additional page if needed)

Name	Dose	Direction

List any self-prescribed medications, dietary supplements, or vitamins you are now taking:

_____

_____

_____

Check those questions to which you answer yes (leave the others blank).

- ☐ Has a doctor ever said your blood pressure was too high?
- ☐ Do you ever have pain in your chest or heart?
- ☐ Are you often bothered by a thumping of the heart?
- ☐ Does your heart often race or ever notice extra heartbeats or skipped beats?
- ☐ Are your ankles often badly swollen?
- ☐ Do cold hands or feet trouble you even in hot weather?
- ☐ Has a doctor ever said that you have or have had heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack or coronary?
- ☐ Do you suffer from frequent cramps in your legs?
- ☐ Do you often have difficulty breathing?
- ☐ Do you get out of breath long before anyone else?
- ☐ Do you sometimes get out of breath when sitting still or sleeping?
- ☐ Has a doctor ever told you your cholesterol level was high?
- ☐ Has a doctor ever told you that you have an abdominal aortic aneurysm?
- ☐ Has a doctor ever told you that you have carotid/aortic stenosis (narrowing)?
- ☐ Has a doctor ever told you that you have a deep vein thrombosis (blood clot)?

Do you now have or have you recently experienced? (check all that apply)

- ☐ Chronic, recurrent or morning cough?
- ☐ Episode of coughing up blood?
- ☐ Increased anxiety or depression?
- ☐ Problems with recurrent fatigue, trouble sleeping or increased irritability?
- ☐ Migraine or recurrent headaches?
- ☐ Swollen, stiff or painful joints?
- ☐ Pain in your legs after walking short distances?
- ☐ Foot problems?
- ☐ Back problems?
- ☐ Stomach or intestinal problems, such as recurrent heartburn, ulcers, abdominal pain, constipation or diarrhea?
- ☐ Do you have hernia (s)? Does it cause you to have pain?
- ☐ Feeling dehydrated and weak?
- ☐ Problem with speaking and/or swallowing?
- ☐ Recent change in a wart or a mole?
- ☐ An infection such as pneumonia accompanied by a fever?

- ☐ Significant unexplained weight loss?
- ☐ Foot or ankle sores that won't heal?
- ☐ History of unsteady gaits and/or repeated falls?
- ☐ Persistent pain or problems walking after you have fallen?
- ☐ Tremors or shakes?
- ☐ Persistent numbness, tingling or pain in the hands and/or feet?
- ☐ Significant vision or hearing problems?
- ☐ Glaucoma or increased pressure in the eyes?
- ☐ Exposure to loud noises for long periods?
- ☐ Eye conditions such as bleeding in the retina or detached retina?
- ☐ Cataract or lens transplant?
- ☐ Laser treatment or other eye surgery?

HEALTH MAINTENANCE QUESTIONAIRE

Date of last complete physical examination: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last dental examination: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last eye examination: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last electrocardiogram (EKG or ECG): _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last colonoscopy: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Women only answer the following.

- ☐ Menstrual period problems? _____
- ☐ Significant childbirth - related problems? _____
- ☐ Urine loss when you cough, sneeze or laugh? _____
- ☐ Are you on any type of hormone replacement therapy? _____

Date of last mammogram:_____

Date of last pelvic exam/or pap smear:_____

List any other medical or diagnostic test you have had in the past two years: _____

_____

_____

Have you had any of this vaccine? If so, when?

- Flu vaccine_____
- Tdap_____
- Pneumonia vaccine_____
- Shingle vaccine_____
- Hepatitis vaccines_____

Past Medical History

Check those questions to which your answer is yes (leave others blank).

- ☐ Heart-attack; when? _____
- ☐ Rheumatic/ Scarlet Fever
- ☐ Heart murmur
- ☐ Irregular Heart Rate
- ☐ Diseases of the arteries
- ☐ Varicose veins
- ☐ Diabetes, abnormal blood-sugar tests or insulin use
- ☐ Phlebitis (inflammation of a vein)
- ☐ Dizziness or fainting spells
- ☐ Epilepsy or seizures
- ☐ Stroke
- ☐ Cancers (*Skin, Colon, Bone, Brain, Prostate, Breast, Uterine and Ovarian)*
- ☐ Kidney disease
- ☐ Congestive Heart Failure
- ☐ Infectious mononucleosis
- ☐ Nervous/emotional problems
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Pneumonia
- ☐ Bronchitis/COPD
- ☐ Asthma
- ☐ Abnormal chest X-ray
- ☐ Other lung disease
- ☐ Injuries to back, arms, legs or joint
- ☐ Broken bones
- ☐ Arthritis of legs or arms
- ☐ Jaundice/gallbladder
- ☐ Amputation

List any surgeries you have had in the past, including date, and the reasons: _____

_____

_____

List any recent hospitalizations, including dates of and reasons for hospitalization:_____

_____

_____

FAMILY MEDICAL HISTORY

Father:

□Alive Current age _____

My father's general health is:

□ Excellent □Good □Fair □Poor; Reason for poor health:_____

□ Deceased □ Age at death _____

Cause of death:_

Mother:

□ Alive Current age _____

My mother's general health is:

□Excellent □Good □Fair □Poor; Reason for poor health:_____

□ Deceased □ Age at death _____

Cause of death: _____

Siblings:

Number of brothers _____ Number of sisters _____ Age range _____

Health problems _____

Familial Diseases: Have you or your blood relatives had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives)?

Check those to which the answer is yes (leave other blank).

- ☐ Heart attacks under age 50
- ☐ Strokes under age 50
- ☐ High blood pressure
- ☐ Elevated cholesterol
- ☐ Diabetes
- ☐ Asthma or hay fever
- ☐ Congenital heart disease (existing at birth but not hereditary)
- ☐ Heart operations
- ☐ Glaucoma
- ☐ Obesity (20 or more pounds overweight)
- ☐ Leukemia or cancer under age 60

Comments: _____

_____

_____

_____

Thank you again for taking the time to complete your
medical history and screening questionnaire.
We are looking forward to working with you
to help you achieve your health goals.

THANK YOU!

Please call us with any questions.

386-206-2929