

Health History Questionnaire

Name _____ Date of birth _____

Address _____

Local phone number _____ Alternative phone number _____

Do you authorize HOPE REGIONAL to leave health information on your voicemail? YES NO

Please check what brings you in today:

- Primarily to establish care
- Other (please briefly describe) _____

Special Communication Needs		Language preference:	
If 'yes' to any of the questions below, how can we assist?			
Visual impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cognitive impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensory impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	

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
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Seizures	<input type="checkbox"/> Heart surgery	
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Headaches	<input type="checkbox"/> Carotid artery surgery	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Vascular surgery / stent	
<input type="checkbox"/> Heart attack or angina	<input type="checkbox"/> Prostate problem	<input type="checkbox"/> Abdominal aneurysm repair	
<input type="checkbox"/> Irregular heart rhythm	<input type="checkbox"/> Breast problem	<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Urinary tract infections	<input type="checkbox"/> Gallbladder removed	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Appendix removed	
<input type="checkbox"/> Emphysema or chronic bronchitis	<input type="checkbox"/> Cancer (Please list type)	<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Thyroid problem	<input type="checkbox"/> Joint replacement	
<input type="checkbox"/> Gastroesophageal reflux disease	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Breast cancer surgery	
<input type="checkbox"/> Stomach ulcer	<input type="checkbox"/> Addiction Issues	<input type="checkbox"/> Prostate cancer surgery	
<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Depression or anxiety	<input type="checkbox"/> Hernia	
<input type="checkbox"/> Liver disease/hepatitis	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Colon cancer	<input type="checkbox"/> Other (please describe)	<input type="checkbox"/> Other (please describe)	
<input type="checkbox"/> Bowel/digestive problem			

Social History:

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

Occupation: _____
Occupational concerns: Stress Hazardous substances Heavy lifting

How stressful would you rate your current living situation: (Circle number)
No stress 0 1 2 3 4 5 6 7 8 9 10 Very Stressful

Are there financial concerns that affect your ability to seek healthcare? No Yes If yes, describe below

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

<input type="checkbox"/> Chest pain	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Black/tarry stools	<input type="checkbox"/> Loss of vision	<input type="checkbox"/> Pain in testicles
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Double vision	<input type="checkbox"/> Loss of libido
<input type="checkbox"/> Cough	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Impotence
<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Breast pain
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Pain in ears	<input type="checkbox"/> Breast discharge
<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Other (please describe below)
<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Constipation	<input type="checkbox"/> Hoarseness	
<input type="checkbox"/> Fast heartbeat	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Easy bleeding	
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Easy bruising	
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Urine frequency	<input type="checkbox"/> Rash	
<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Decrease in urine flow	<input type="checkbox"/> Changes in mole	Females - Please complete
<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> Urine leakage	<input type="checkbox"/> Sore that won't heal	Menstrual flow:
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Headache	<input type="checkbox"/> Fatigue/lethargy	<input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. <input type="checkbox"/> Pain/cramps
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Weakness	<input type="checkbox"/> Insomnia	Days of flow ___ Length of cycle ___
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Loss of strength	<input type="checkbox"/> Forgetfulness	1st day of last period _____
<input type="checkbox"/> Ankle swelling	<input type="checkbox"/> Balance problems	<input type="checkbox"/> Depression	<input type="checkbox"/> Pain or bleeding after sex
<input type="checkbox"/> Nausea	<input type="checkbox"/> Pain, weakness, or numbness in		Number of pregnancies ___
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Arms	<input type="checkbox"/> Hips	<input type="checkbox"/> Back
<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Legs	<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulders
<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Hands	<input type="checkbox"/> Feet	Birth control method _____

Family History

Relationship	Living /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
<input type="checkbox"/> Mental illness		<input type="checkbox"/> Chemical dependency	

Allergies:

Please list any allergies to medications or foods

Medications:

Please list any medications that you take including over the counter medications, herbs, and supplements. Include dose and frequency.

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 <input type="checkbox"/> Yes <input type="checkbox"/> No		Pap smear/pelvic <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pneumonia vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No		Mammogram <input type="checkbox"/> Yes <input type="checkbox"/> No	
Influenza vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No		Bone dxa <input type="checkbox"/> Yes <input type="checkbox"/> No	
Shingles vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No		Colonoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hemoccult (stool card) <input type="checkbox"/> Yes <input type="checkbox"/> No		Prostate test <input type="checkbox"/> Yes <input type="checkbox"/> No	

Specialty Providers:

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.

<input type="checkbox"/> Eye doctor	<input type="checkbox"/> Nephrologist
<input type="checkbox"/> Cardiologist	<input type="checkbox"/> Psychiatrist
<input type="checkbox"/> Oncologist	<input type="checkbox"/> Allergist
<input type="checkbox"/> Urologist / Gynecologist	<input type="checkbox"/> Vascular
<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> Pulmonologist
<input type="checkbox"/> Endocrinologist	<input type="checkbox"/> Other

Health Behaviors:

Tobacco use: <input type="checkbox"/> Never <input type="checkbox"/> Quit (when) _____ <input type="checkbox"/> Current smoker	
If current smoker how many packs per day for how many years _____ Are you willing to quit? _____	
Alcohol intake: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes how many drinks/how often _____	
Illicit drug use (including marijuana, cocaine, steroids): <input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current	
If past or current drug use describe: _____	
Exposure to secondhand smoke <input type="checkbox"/> Yes <input type="checkbox"/> No	Wear a seatbelt <input type="checkbox"/> Yes <input type="checkbox"/> No
Eat a diet high in fruits and vegetables <input type="checkbox"/> Yes <input type="checkbox"/> No	See a dentist at least once a year <input type="checkbox"/> Yes <input type="checkbox"/> No
Get 30 minutes of exercise 5 times a week <input type="checkbox"/> Yes <input type="checkbox"/> No	Wear sunscreen <input type="checkbox"/> Yes <input type="checkbox"/> No

Advance Care Planning:

Do you currently have, or would you like information on, any of the following items:		
Living Will:	<input type="checkbox"/> Have	<input type="checkbox"/> Don't Have <input type="checkbox"/> Want Information
Durable Power of Attorney:	<input type="checkbox"/> Have	<input type="checkbox"/> Don't Have <input type="checkbox"/> Want Information
DNR Order:	<input type="checkbox"/> Have	<input type="checkbox"/> Don't Have <input type="checkbox"/> Want Information
Other:	<input type="checkbox"/> Have	<input type="checkbox"/> Don't Have <input type="checkbox"/> Want Information

