**patient demographics**

|  |
| --- |
| **Patient information** |
| **Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security #**: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_**Date of Birth**: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ **Sex**: M F **Phone Number**: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_**Mailing Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address City State Zip Code**Physical Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address City State Zip Code**Email Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Employer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employed**: Full Time Part Time Retired Disabled |

|  |
| --- |
| **RESPONSIBLE PARTY INFORMATION** |
| **Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone Number**: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ **Mailing Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address City State Zip Code**Relationship to Patient**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **EMERGENCY CONTACT INFORMATION** |
| **Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone Number**: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_**Relationship to Patient**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **SIGNATURE** |
| **Signature of Person Completing Form**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship to Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ |

**Insurance Information**

Primary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Patient Relationship to Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| hEALTH HISTORY QUESTIONNAIRE |
| All questions contained in this questionnaire are strictly confidential and will become part of your medical record. |
| Name (Last, First, M.I.): |       | [ ]  M [ ]  F | DOB: |       |
| Marital status: | **[ ]  Single [ ]  Partnered [ ]  Married [ ]  Separated [ ]  Divorced [ ]  Widowed** |
| Date of last physical exam: |       | Previous or referring doctor: |       |
|  |
| PERSONAL HEALTH HISTORY |
|  |
| Childhood illness: | ¨ Measles ¨ Mumps ¨ Rubella ¨ Chickenpox ¨ Rheumatic Fever ¨ Polio |
| Immunizations and dates: | [ ]  Tetanus |       | [ ]  Pneumonia       | [ ]  Influenza       |
|  | [ ]  Hepatitis |       | [ ]  Chickenpox       | [ ]  MMR Measles, Mumps, Rubella       |
|  | [ ]  Covid- 19 |       |  |  |
| List any medical problems that other doctors have diagnosed |
|       |
|  |
|  |
|  |
| Surgeries |
| Year | Reason | Hospital |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| Other hospitalizations |
| Year | Reason | Hospital |
|       |       |       |
|       |       |       |
|       |       |       |
|  |
| Have you ever had a blood transfusion? | [ ]  | Yes | [ ]  | No |
|  |
| List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers |
| Name the Drug | Strength | Frequency Taken |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| Allergies to medications |
| Name the Drug | Reaction You Had |
|       |       |
|       |       |
|       |       |
|  |
| HEALTH HABITS AND PERSONAL SAFETY |
|  |
| All questions contained in this questionnaire are optional and will be kept strictly confidential. |
| Exercise | [ ]  Sedentary (No exercise) |
|  | [ ]  Occasional exercise (i.e., climb stairs, walk 3 blocks, golf) |
|  | [ ]  Moderate exercise (i.e., work or recreation, less than 4x/week for 30 min.) |
|  | [ ]  Heavy exercise (i.e., work or recreation 4x/week for 30 minutes) |
| Diet | Are you dieting? | [ ]  | Yes | [ ]  | No |
|  | If yes, are you on a physician prescribed medical diet? | [ ]  | Yes | [ ]  | No |
|  | # of meals you eat in an average day?       |
|  | Rank salt intake | [ ]  Hi | [ ]  Med | [ ]  Low |
|  | Rank fat intake | [ ]  Hi | [ ]  Med | [ ]  Low |
| Caffeine | ¨ None | [ ]  Coffee | [ ]  Tea | [ ]  Cola |
|  | # of cups/cans per day?       |
| Alcohol | Do you drink alcohol? | [ ]  | Yes | [ ]  | No |
|  | If yes, what kind?       |
|  | How many drinks per week?       |
|  | Are you concerned about the amount you drink? | [ ]  | Yes | [ ]  | No |
|  | Have you considered stopping? | [ ]  | Yes | [ ]  | No |
|  | Have you ever experienced blackouts? | [ ]  | Yes | [ ]  | No |
|  | Are you prone to “binge” drinking? | [ ]  | Yes | [ ]  | No |
|  |  | [ ]  |  | [ ]  |  |
| Tobacco | Do you use tobacco? | [ ]  | Yes | [ ]  | No |
|  | [ ]  Cigarettes – pks./day       | [ ]  Chew - #/day       | [ ]  Pipe - #/day       | [ ]  Cigars - #/day       |
|  | [ ]  # of years       | [ ]  Or year quit       |
| Drugs | Do you currently use recreational or street drugs? | [ ]  | Yes | [ ]  | No |
|  | Have you ever given yourself street drugs with a needle? | [ ]  | Yes | [ ]  | No |
| Sex | Are you sexually active? | [ ]  | Yes | [ ]  | No |
|  | If yes, are you trying for a pregnancy? | [ ]  | Yes | [ ]  | No |
|  | If not trying for a pregnancy list contraceptive or barrier method used:       |
|  | Any discomfort with intercourse? | [ ]  | Yes | [ ]  | No |
|  | Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? |  |  |  |  |
|  |  | [ ]  | Yes | [ ]  | No |
| Personal Safety | Do you live alone? | [ ]  | Yes | [ ]  | No |
|  | Do you have frequent falls? | [ ]  | Yes | [ ]  | No |
|  | Do you have vision loss? | [ ]  | Yes | [ ]  | No |
|  | Do you have hearing loss? | [ ]  | Yes | [ ]  | No |
|  | Do you have an Advance Directive and/or Living Will? | [ ]  | Yes | [ ]  | No |
|  | Would you like information on the preparation of these? | [ ]  | Yes | [ ]  | No |
|  | Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? |  |  |  |  |
|  |  | [ ]  | Yes | [ ]  | No |

|  |
| --- |
| FAMILY HEALTH HISTORY |
|  |
|  | Age | Significant Health Problems |  | Age | Significant Health Problems |
| Father |       |       | Children | [ ]  M[ ]  F |  |       |
| Mother |       |       | [ ]  M[ ]  F |  |       |
| Sibling | [ ]  M[ ]  F |  |       | [ ]  M[ ]  F |  |       |
| [ ]  M[ ]  F |  |       | [ ]  M[ ]  F |  |       |
| [ ]  M[ ]  F |  |       | GrandmotherMaternal |       |       |
| [ ]  M[ ]  F |  |       | GrandfatherMaternal |       |       |
| [ ]  M[ ]  F |  |       | GrandmotherPaternal |       |       |
| [ ]  M[ ]  F |  |       | GrandfatherPaternal |       |       |

|  |
| --- |
| **Please check any of the following symptoms that you have or have had in the last 30 days.** |
| **Constitutional** |

|  |  |
| --- | --- |
| [ ]  Fever[ ]  Night Sweats[ ]  Significant weigh gain[ ]  Significant weight loss | [ ]  Exercise intolerance[ ]  Sedation[ ]  Lethargy or malaise[ ]  Chills |

  |
| **Eyes** |

|  |  |
| --- | --- |
| [ ]  Wears glasses or contact lenses[ ]  Dry eyes[ ]  Irritation | [ ]  Vision changes[ ]  Eye disease[ ]  Eye injury |

 |
| **ENMT** | Ears

|  |  |
| --- | --- |
| [ ]  Difficulty hearing | [ ]  Ear Pain |

Nose

|  |  |
| --- | --- |
| [ ]  Frequent nose bleeds[ ]  Sinus problems | [ ]  Nose problems |

Mouth/Throat

|  |  |
| --- | --- |
| [ ]  Sore throat [ ]  Bleeding gums[ ]  Soring[ ]  Dry mouth[ ]  Oral abnormalities | [ ]  Mouth ulcer[ ]  Teeth abnormalities[ ]  Mouth breathing[ ]  Ringing in the ears[ ]  Sinusitis |

 |
| **Cardiovascular** |

|  |  |
| --- | --- |
| [ ]  Chest pain on exertion[ ]  Arm pain on exertion[ ]  Shortness of breath when walking[ ]  Shortness of breath when lying down | [ ]  Palpitations[ ]  Known heart murmur[ ]  Light-headed on standing[ ]  Ankle swelling |

 |
| **Respiratory** |

|  |  |
| --- | --- |
| [ ]  Cough[ ]  Wheezing[ ]  Shortness of breath | [ ]  Coughing up blood[ ]  Sleep apnea |

 |
| **Gastrointestinal** |

|  |  |
| --- | --- |
| [ ]  Abdominal pain[ ]  Nausea[ ]  Vomiting[ ]  Constipation[ ]  Change in appetite | [ ]  Black or tarry stools[ ]  Frequent diarrhea[ ]  Vomiting blood[ ]  Dyspepsia[ ]  GERD |

 |
| **Genitourinary** |

|  |  |
| --- | --- |
| [ ]  Urinary loss of control[ ]  Difficulty urinating[ ]  Increased urinary frequency | [ ]  Hematuria (blood in your urine)[ ]  Incomplete emptying |

 |
| **Musculoskeletal** |

|  |  |
| --- | --- |
| [ ]  Muscle aches muscle weakness[ ]  Arthralgias/joint pain[ ]  Backpain[ ]  Swelling in extremities | [ ]  Neck pain[ ]  Difficulty walking[ ]  Cramps[ ]  Osteoporosis[ ]  Fractures |

 |
| **Skin** |

|  |  |
| --- | --- |
| [ ]  Abnormal mole[ ]  Jaundice[ ]  Rash[ ]  Itching[ ]  Dry skin[ ]  Growths/lesions | [ ]  Laceration[ ]  Non-healing areas[ ]  Changes in hair/nails[ ]  Psoriasis[ ]  Change in skin color[ ]  Breast lump |

 |
| **Neurologic** |

|  |  |
| --- | --- |
| [ ]  Loss of consciousness[ ]  Weakness[ ]  Numbness[ ]  Seizures[ ]  Dizziness[ ]  Frequent or severe headaches | [ ]  Migraines[ ]  Restless legs[ ]  Tremor[ ]  Gait dysfunction[ ]  Paralysis |

 |
| **Psychiatric** |

|  |  |
| --- | --- |
| [ ]  Depression[ ]  Sleep disturbances[ ]  Feeling unsafe in relationship[ ]  Restless sleep[ ]  Alcohol abuse[ ]  Anxiety[ ]  Hallucinations | [ ]  Suicidal thoughts [ ]  Mood swings[ ]  Memory loss[ ]  Agitation[ ]  Dementia[ ]  Delirium |

 |
| **Endocrine** |

|  |  |
| --- | --- |
| [ ]  Fatigue[ ]  Increased thirst [ ]  Hair loss | [ ]  Increased hair growth [ ]  Cold intolerance |

 |
| **Hematologic/ Lymphatic** |

|  |  |
| --- | --- |
| [ ]  Swollen glands[ ]  Easy bruising[ ]  Excessive bleeding | [ ]  Anemia[ ]  Phlebitis |

 |
| **Allergy/ Immunologic** |

|  |  |
| --- | --- |
| [ ]  Runny nose[ ]  Sinus pressure[ ]  Itching | [ ]  Hives [ ]  Frequent sneezing |

 |

|  |
| --- |
| MENTAL HEALTH |
|  |
| Is stress a major problem for you? | [ ]  | Yes | [ ]  | No |
| Do you feel depressed? | [ ]  | Yes | [ ]  | No |
| Do you panic when stressed? | [ ]  | Yes | [ ]  | No |
| Do you have problems with eating or your appetite? | [ ]  | Yes | [ ]  | No |
| Do you cry frequently? | [ ]  | Yes | [ ]  | No |
| Have you ever attempted suicide? | [ ]  | Yes | [ ]  | No |
| Have you ever seriously thought about hurting yourself? | [ ]  | Yes | [ ]  | No |
| Do you have trouble sleeping? | [ ]  | Yes | [ ]  | No |
| Have you ever been to a counselor? | [ ]  | Yes | [ ]  | No |

|  |
| --- |
| men and women |

|  |  |  |
| --- | --- | --- |
| Any urinary tract, bladder, kidney, or prostate infections within the last year? | [ ]  Yes | [ ]  No |
| Do you feel pain or burning with urination? | [ ]  Yes | [ ]  No |
| Any blood in your urine? | [ ]  Yes | [ ]  No |
| Any problems with control of urination? | [ ]  Yes | [ ]  No |
| Do you have any problems emptying your bladder completely? | [ ]  Yes | [ ]  No |
| Do you usually get up to urinate during the night? | [ ]  Yes | [ ]  No |
| If yes, how many times a night?       |
| Date of last colonoscopy?       |

|  |
| --- |
| WOMEN ONLY |
|  |
| Age at onset of menstruation:       |
| Date of last menstruation:       |
| Period every       days |
| Heavy periods, irregularity, spotting, pain, or discharge? | [ ]  | Yes | [ ]  | No |
| Number of pregnancies       Number of live births       |
| Are you pregnant or breastfeeding? | [ ]  | Yes | [ ]  | No |
| Have you had a D&C, hysterectomy, or Cesarean? | [ ]  | Yes | [ ]  | No |
| Any hot flashes or sweating at night? | [ ]  | Yes | [ ]  | No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? | [ ]  | Yes | [ ]  | No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? | [ ]  | Yes | [ ]  | No |
| Date of last pap and rectal exam?       |
| Date of last mammogram?       |
|  |
| MEN ONLY |
|  |
| Do you feel burning discharge from penis? | [ ]  | Yes | [ ]  | No |
| Has the force of your urination decreased? | [ ]  | Yes | [ ]  | No |
| Any difficulty with erection or ejaculation? | [ ]  | Yes | [ ]  | No |
| Any testicle pain or swelling? | [ ]  | Yes | [ ]  | No |
| Date of last prostate and rectal exam?       |
|  |
| OTHER PROBLEMS |
|  |
| Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ]  | Skin       | [ ]  | Chest/Heart       | [ ]  | Recent changes in:       |
| [ ]  | Head/Neck       | [ ]  | Back       | [ ]  | Weight       |
| [ ]  | Ears       | [ ]  | Intestinal       | [ ]  | Energy level       |
| [ ]  | Nose       | [ ]  | Bladder       | [ ]  | Ability to sleep       |
| [ ]  | Throat       | [ ]  | Bowel       | [ ]  | Other pain/discomfort:       |
| [ ]  | Lungs       | [ ]  | Circulation       |  |  |

**ADDITIONAL NOTES:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**