Health Questionnaire

Patient's Name ____ Date of Birth _________________

Race American Indian, Black, Decline, Hispanic, Other, Asian, Unknown, White

Ethnicity Decline, Hispanic, Non-Hispanic

Language ________________

1. **What are the names of your specialists?**

   Cardiologist___________________________
   Colon/Rectal__________________________
   Dentist_______________________________
   Eye__________________________________
   GI___________________________________
   Gynecologist__________________________
   Orthopedist___________________________
   Other________________________________
   Other________________________________
   Podiatrist____________________________
   Pulmonary____________________________
   Urologist_____________________________

2. What lab do you use for blood work? Quest Collaborative Clinical Lab
3. What pharmacy do you use? (name, address, phone)_____________________________________
   ____
   ____
4. What is your email address?________________________________

   May we contact you by email?..yes/no

5. **General Health:** In general, would you say your health is:

   Excellent Very Good Good Fair Poor

   How much bodily pain have you had during the past 4 weeks?

   None Very Mild Mild Moderate Severe Very Severe

6. **Review of Systems:**

a. Do you have difficulty driving, watching TV or reading because of poor eyesight?.......yes / no

b. Can you hear normal conversational voice?..yes / no

   Do you use hearing aids?..yes / no

c. Do you have problems with your memory?………………………………………….. yes / no

d. Do you often feel sad or depressed?.. yes / no

e. Have you unintentionally lost weight in the last 6 months?... yes / no

f. Do you have trouble with control of your bladder? ……………………………………..yes / no

   Do you have trouble with control of your bowels?.. yes / no

g. How many falls have you had in the past year?..#____

h. Do you drink alcohol?.. yes / no

   If yes, how many drinks per week?..#____

i. Do you use tobacco products?...yes / no

   If yes, how many years ______ How many per day ______

7. Do you live with anyone?……………………………………………………………………… yes / no
   If yes, who? Spouse Child Other Relative Friend
   Who would help you in an emergency?____
   Who would help you with heath care decisions if you were not able to communicate your wishes?____
   Do you have a Living Will for health care?..yes / no
8. How many medicines do you take, including prescribed, over the counter and vitamins? _________
   What is your system for taking your medications?
   Pill Box Family help List/Chart None
9. Do you use sunscreen?... yes / no
10. Are you sexually active?.. yes / no
11. Do you drive?...yes / no
    Do you wear a seat belt?.. yes / no
    Do you wear a helmet?.. yes / no
12. Has anyone intentionally tried to harm you?...yes / no
13. Are there guns in your household?... yes / no
14. Have you had an influenza shot (flu shot) this year?... yes / no
15. Have you had a shot to prevent pneumonia?.. yes / no

16. **Activities of Daily Living:** Are you **(I)** Independent (can do by myself), **(A)** require assistance (need help from another person), or **(D)** Dependent (can not do at all) with the following tasks?

Walking	I	A	D	Using Telephone	I	A	D
Dressing	I	A	D	Shopping	I	A	D
Bathing	I	A	D	Preparing Meals	I	A	D
Eating	I	A	D	Housework	I	A	D
Toileting	I	A	D	Taking Medications	I	A	D
Driving	I	A	D	Managing Finances	I	A	D

Patient Signature:____ Date:________________
Reviewing Physician:____ Date:________________

Please bring this completed form and your medications to your appointment. Thank you.