Bull City Family Medicine and Pediatrics

Date:_____ **Health History Questionnaire:**

Name_____ Preferred Pronoun _____ D.O.B _____

Address_____

_____

Phone: _____

Please describe what problem or concern brought you to our office today: _____

☐ Primarily to establish care

Health Behaviors:

Tobacco use: ☐ Never ☐ Used to smoke ____ pks/day for ____ years Year quit smoking _____

☐ Current smoker - Packs day _____ ☐ Exposure to secondhand smoke ☐ yes ☐ no

******QUIT SMOKING THIS IS THE MOST IMPORTANT THING YOU CAN DO FOR YOUR HEALTH******

Alcohol intake: ☐ No ☐ Yes If yes how many drinks/per day_____

****I recommend you limit to 2 drinks per day. Two can be heart healthy but > 2 can increase your risk of certain cancers****

Caffeine: (soda, coffee, tea) ☐ No ☐ Yes If yes how many drinks per day _____

****** I recommend you limit to two a day and not after noon******

*****Caffeine can cause palpitations, reflux and anxiety*****

Illicit drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current

If past/current drug use please describe:_____

Sleep _____ hours a day

**** I recommend you sleep 8 hours daily****

Get 30 minutes of exercise 5 times a week ☐ Yes ☐ No

Exercise type _____/ # a week _____

****I recommend 30 minutes of exercise daily 5 times a week****

See a dentist twice a year: ☐ Yes ☐ No

Dr: _____ Last appointment: _____

See and eye doctor every year: ☐ Yes ☐ No

Dr: _____ Last appointment: _____

I eat a diet high in fruits and vegetables	☐ Yes	☐ No
I eat red meat LESS than 3 times a week	☐ Yes	☐ No
I eat out LESS than 3 times a week	☐ Yes	☐ No
I eat fried food LESS than 2 times a week	☐ Yes	☐ No
I get at least 3 servings of dairy in my diet	☐ Yes	☐ No
I am on a low carb diet	☐ Yes	☐ No

**** I recommend eating regularly, avoid skipping meals and stay on a low sugar and low-fat diet****

Wear a seatbelt ☐ Yes ☐ No

**** I recommend you wear your seat belt 100% of the time****

Wear sunscreen Yes No

**** I recommend daily use of sunscreen and staying out of the sun to prevent skin cancer****

Medications/Herbals

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

Allergies

Please list any medications allergies to medications or food

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

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

Medical Health History

Please check past or current problems or conditions

Condition	Condition
☐ Hypertension	☐ Seizures
☐ High cholesterol	☐ Headaches
☐ Diabetes	☐ Stroke
☐ Heart attack or angina	☐ Prostate problem
☐ Irregular heart rhythm	☐ Breast problem
☐ Congestive heart failure	☐ Urinary tract infections
☐ Asthma	☐ Osteoarthritis
☐ Emphysema or chronic bronchitis	☐ Cancer (Please list type)
☐ Pneumonia	☐ Thyroid problem
☐ Gastroesophageal reflux disease	☐ Bleeding disorder
☐ Stomach ulcer	☐ Addiction Issues
☐ Kidney problems	☐ Depression or anxiety
☐ Liver disease/hepatitis	☐ Mental Illness
☐ Colon cancer	☐ Other (please describe)
☐ Bowel/digestive problem	

Previous Surgical Procedures

Please check if you have had any of the following

Procedure	Year
☐ Heart surgery	
☐ Carotid artery surgery	
☐ Vascular surgery / stent	
☐ Abdominal aneurysm repair	
☐ Hysterectomy	
☐ Gallbladder removed	
☐ Appendix removed	
☐ Tonsillectomy	
☐ Joint replacement	
☐ Breast cancer surgery	
☐ Prostate cancer surgery	
☐ Hernia	
☐ Pacemaker	
☐ Other (please describe)	

Specialty Providers:	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice and list when you last saw them	
☐ Eye doctor	☐ Nephrologist
☐ Cardiologist	☐ Psychiatrist
☐ Oncologist	☐ Therapist
☐ Urologist / Gynecologist	☐ Vascular
☐ Gastroenterologist	☐ Pulmonologist
☐ Endocrinologist	☐ Dentist ☐ Other

Family History

Relationship	Living Y/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
☐ Heart Attack <65			☐ Colon Cancer	
☐ Breast Cancer			☐ Mental Illness	
☐ Ovarian Cancer			☐ Chemical Dependency	
☐ Aneurysm				

Fall Risk Screening	
In the last 12 months have you fallen? ☐ Yes ☐ No ☐ Unsure	If yes, how many times? ☐1 ☐2 ☐3 ☐4 ☐5+
Were you injured as a result of this fall? ☐ Yes ☐ No ☐ Unsure	Do you have any problems with gait or balance? ☐ Yes ☐ No

Special Communication Needs:			
Language preference:			
If 'yes' to any of the questions below, how can we assist?			
Visual impairment	☐ Yes ☐ No	Cognitive impairment	☐ Yes ☐ No
Hearing impairment	☐ Yes ☐ No	Sensory impairment	☐ Yes ☐ No
Speech impairment	☐ Yes ☐ No	Other:	

Advance Care Planning:			
Do currently have, or would you like information on, any of the following items			
Living Will: Please give us a copy	☐ Have	☐ Don't Have	☐ Want Information
Durable Power of Attorney:	☐ Have	☐ Don't Have	☐ Want Information
DNR Order:	☐ Have	☐ Don't Have	☐ Want Information

Health Literacy Questionnaire	
Many times in healthcare staff and providers use words that are unfamiliar to the general population. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree	
I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my health	1 2 3 4 5 6 7 8 9 10
I feel that I remember the instructions given to me at my doctor's office when I get home	1 2 3 4 5 6 7 8 9 10
I feel that I have a strong understanding of medical language	1 2 3 4 5 6 7 8 9 10

Patient Signature:_____ Date:_____

Reviewed by: _____ Date:_____