

# Bull City Family Medicine and Pediatrics

## Health History Questionnaire

Date \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_ Preferred Pronoun \_\_\_\_\_ D.O.B \_\_\_/\_\_\_/\_\_\_

Preferred Local Pharmacy \_\_\_\_\_

Preferred Mail Order Pharmacy \_\_\_\_\_

### Current Health Concerns / Reason for Visit

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### Health Behaviors

Compared with other people your age, how has your health been in the past 4 weeks?

Excellent     Very Good     Good     Fair     Poor

Tobacco use:     Never     Used to smoke \_\_\_ pks/day for \_\_\_ years    Year quit smoking \_\_\_\_\_

Current smoker - Packs a day \_\_\_\_\_     Exposure to secondhand smoke     Yes     No

Vape use:     Never     Current     Used to vape

Cannabis use:     Never     Current     Used to smoke

Alcohol intake:     No     Yes    If yes, how many drinks/per day \_\_\_\_\_

Caffeine:     No     Yes    If yes, how many drinks per day \_\_\_\_\_

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

If past/current drug use, please describe:

How many hours of sleep do you get a day \_\_\_\_\_

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

Exercise type \_\_\_\_\_ How many times a week \_\_\_\_\_

Wear a seatbelt?     Yes     No

Wear sunscreen?     Yes     No

See a dentist twice a year:     Yes     No

Dr: \_\_\_\_\_ Last appointment: \_\_\_\_\_

See an eye doctor every year:     Yes     No

Dr: \_\_\_\_\_ Last appointment: \_\_\_\_\_

Do you eat a diet high in fruits and vegetables?     Yes     No

Do you eat red meat LESS than 3 times a week?     Yes     No

Do you eat out LESS than 3 times a week?     Yes     No

Do you eat fried food LESS than 2 times a week?     Yes     No

Do you get at least 3 servings of dairy in my diet?     Yes     No

Are you on a low carb diet?     Yes     No

### Pain Assessment

Are you currently experiencing any pain?  Yes  No

Location of pain:

On a scale of 0 -10 (0 being no pain and 10 being the worst possible pain) please rate your pain below

0 1 2 3 4 5 6 7 8 9 10

### 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

### Mood Screening

A person's mood can have a strong influence on their health status and overall wellbeing. Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things?

Not at all

Several days

More than half the days

Nearly every day

Feeling down, depressed, or hopeless

Not at all

Several days

More than half the days

Nearly every day

### Special Communication Needs

Language preference:

If 'yes' to any of the questions below, how can we assist?

Visual impairment  Yes  No  Glasses/Contacts

Cognitive impairment

Yes  No

Hearing impairment  Yes  No  Hearing aids

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 **\*\*Please give us a copy\*\***

Living Will:

Have  Don't Have  Want Information

Durable Power of Attorney for Health Care:

Have  Don't Have  Want Information

DNR Order:

Have  Don't Have  Want Information

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_