Bull City Family Medicine and Pediatrics

Health History Questionnaire

Date ____/____/ _____

Name_____ **Preferred Pronoun** ____ **D.O.B** ___/___/_____

Preferred Local Pharmacy _____

Preferred Mail Order Pharmacy _____

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

Allergies	
Please list any medication allergies or allergies to food	

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

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

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

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 / chronic bronchitis	☐ Thyroid problem
☐ Pneumonia	☐ Bleeding disorder
☐ Gastroesophageal reflux disease	☐ Addiction Issues
☐ Stomach ulcer	☐ Depression or anxiety
☐ Kidney problems	☐ Mental Illness
☐ Liver disease/hepatitis	☐ Cancer _____
☐ 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)	

Over-the-Counter Medications/Herbals

Please list any over-the-counter medications, herbs, and supplements.
Include dose and frequency

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	☐ Psychiatrist
☐ Cardiologist	☐ Therapist
☐ Oncologist	☐ Dermatologist
☐ Urologist / Gynecologist	☐ Pulmonologist
☐ Gastroenterologist	☐ Neurologist
☐ Endocrinologist	☐ Dentist
☐ Allergist	☐ Other
☐ Nephrologist	☐ No new specialist

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death ☐ No Changes
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			☐ Pancreatic Cancer	
☐ Aneurysm			☐ Chemical/Opioid Dependency	

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?	Feeling down, depressed, or hopeless
☐ Not at all	☐ Not at all
☐ Several days	☐ Several days
☐ More than half the days	☐ More than half the days
☐ Nearly every day	☐ 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: _____