# 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 |
|---|
| |
| |
| |
| |
| |

| Health Behaviors |
|---|
| Compared with other people your age, how has your health been in the past 4 weeks?<br>☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor |
| Tobacco use: ☐ Never ☐ Used to smoke ____ pks/day for ____ years Year quit smoking _____<br>☐ 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<br>Exercise type _____ How many times a week _____ |
| Wear a seatbelt? ☐ Yes ☐ No |
| Wear sunscreen? ☐ Yes ☐ No |
| See a dentist twice a year: ☐ Yes ☐ No<br>Dr: _____ Last appointment: _____ |
| See an eye doctor every year: ☐ Yes ☐ No<br>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?<br>☐ Yes ☐ No ☐ Unsure | If yes, how many times? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+ |
| Were you injured as a result of this fall?<br>☐ Yes ☐ No ☐ Unsure | Do you have any problems with gait or balance?<br>☐ 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: _____