HEALTH QUESTIONNAIRE
Confidential Data

INDIANA INTERNAL MEDICINE CONSULTANTS – INDIANA PRIMARY CARE ASSOCIATES
CENTER FOR RESPIRATORY & SLEEP MEDICINE – INDIANA INFECTIOUS DISEASE CONSULTANTS

Name: DOB: Date:

Reason for visit and symptoms:

LIST OTHER MEDICAL PERSONNEL INVOLVED IN CARE AND THE REASON		
Name	Phone Number	Reason

ALLERGIES/INTOLERANCES			
Allergen Name	Reaction	Intolerance or Allergy	Start Date
		□ Intolerance □ Allergy	
		□ Intolerance □ Allergy	
		□ Intolerance □ Allergy	
		□ Intolerance □ Allergy	

MEDICATIONS – List <u>all</u> prescription medications you currently take				
Medication	Start date	Strength	How often	Reason
SUPPLEMENTS – List <u>all</u> vitamins, hormones, alternative remedies or over the counter medication you use.				
Supplement	Start date	Strength	How often	Reason

PREVENTATIVE CARE – List date of last test or screening	
Test	Date of last test or screening
Colonoscopy	
Gastroscopy	
Dental examination	
DEXA (bone density)	
Eye examination	

MALE PATIENTS	Date of last test	Please (√) **check below if applicable**
PSA laboratory		□ Urethral discharge
Rectal/prostate examination		□ Urinary: Decreased flow or delayed flow/ejaculation
Testicular examination		□ Problems achieving/maintaining erection
		□ Diminished libido

NO CHANGE SINCE PRIOR HQ Patient initials:_____ Date:_____

HEALTH QUESTIONNAIRE
Confidential Data

FEMALE PATIENTS	Date of last test	Menstrual history
Breast examination		Age of onset:_____ Date of last period:_____ □ regular □ irregular
Mammogram		Flow: □ Heavy □ Mod □ Light □ Pain/cramps w/menstrual flow
Pap smear		Days of flow:_____ Length of cycle:_____
Rectal examination		No. of pregnancies:_____ Live births:_____ Miscarriages:_____
		Birth control method:_____ Age of menopausal onset:_____
		□ Pain after intercourse □ Bleeding after intercourse □ Flushing/menopause □ Diminished libido □ Infertility/infertility problems □ Problems:_____

HEALTH HISTORY: Are you being treated for or have you ever had any of the following health conditions?

Please check (√). Space provided below for details or other health conditions not listed

□ Allergies	□ Colitis	□ *Defibrillator*	□ Nervous system disease
□ Alcohol problems	□ Constipation	□ *Failure*	□ Osteoporosis/osteopenia
□ Anemia	□ COPD	□ *Pacemaker*	□ Obesity
□ Aneurysm	□ Dementia	□ *Palpitations*	□ Peptic ulcer(s)
□ Anxiety	□ Depression	□ *Stents*	□ Peripheral vascular disease
□ Arthritis:	□ Diabetes	□ *Valvular disease*	□ Pleurisy
□ *Osteoarthritis*	*Last: HgA1 C #_____*	□ Hemorrhoids	□ Pneumonia
□ *Degenerative*	*Dilated eye exam_____*	□ Hepatitis A B C other____	□ Prostate problems
□ *Psoriatic*	*Urine for microalbumin _____*	□ High blood pressure	□ Seizure disorder
□ *Rheumatoid*	□ Diarrhea	□ HIV/AIDS	□ Sexually transmitted disease(s)
□ Asthma	□ Diverticulosis/diverticulitis	□ Hyperthyroidism	□ Sleep apnea
□ Atrial fibrillation	□ Eating disorder	□ Hypothyroidism	□ Stroke
□ Bleeding problem	□ Emphysema	□ Irritable bowel	□ TIA
□ Blood clots	□ Fertility issues	□ Kidney disease	□ Tremors
□ Blood transfusion	□ GERD	□ Kidney failure	□ Tuberculosis
□ Bronchitis	□ Glaucoma	□ Kidney stones	□ Urinary:
□ Cancer	□ Goiter	□ Low back pain	□ *Frequency*
□ *Type _____*	□ Gout	□ Lupus (SLE)	□ *Incontinence*
□ CHF	□ Headaches	□ Mental illness/mood disorder_____	□ *Infection(s)*
systolic diastolic	□ Heart	□ MRSA infection(s)	□ *Retention*
Ejection fraction _____	□ *Arrhythmia*	□ Narcolepsy	□ Varicose veins
□ Crohn's disease	□ *CAD (MI)*	□ Neuropathy	□ Weight problems

List additional information and other health conditions not listed above:

_____

_____

PAST PROCEDURES/SURGERIES – List surgical procedures, reasons for hospitalizations and the year

Type	Approximate date	Type	Approximate date

NO CHANGE SINCE PRIOR HQ Patient initials:_____ Date:_____

HEALTH QUESTIONNAIRE
Confidential Data

IMMUNIZATIONS – List date of last injection and if record is attached

Injection	Date	Record attached?	Injection	Date	Record attached?
Gardasil		□ Yes □ No	Pneumonia		□ Yes □ No
Hepatitis A		□ Yes □ No	Polio		□ Yes □ No
Hepatitis B		□ Yes □ No	Tetanus		□ Yes □ No
Influenza		□ Yes □ No	Tdap		□ Yes □ No
MMR		□ Yes □ No	Typhoid		□ Yes □ No
Meningitis		□ Yes □ No	Zostavax		□ Yes □ No

SOCIAL HISTORY

Smoking status □ Current every day smoker □ Current someday smoker □ Former smoker □ Never smoker
□ Smoker, current status unknown
If Current or Quit within 12 months □ Cigarettes □ Cigars □ Pipe □ Smokeless Amount?_____ Duration?_____
If Current or Quit within 12 months, Smoking Cessation Counseling? □ Yes □ No If yes, list date of counseling:_____

Preferred language: _____
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino
Race: □ White □ African-American □ American Indian/Alaskan □ Asian □ Hawaiian/Pacific Islander □ Other_____

Relationship status: □ Married □ Single □ Widowed □ Divorced □ Other

How do you identify your sexual orientation? □ Heterosexual (opposite sex partner) □ Gay/lesbian(same sex partner)
□ Bisexual □ Transgender – If transgender, how would you like to be addressed?_____

Alcohol? □ Yes □ No □ Rarely Amount_____per day/wk/mos. | **Caffeine?** □ Yes □ No ____cups per day/wk/mos

Do you/or have you had a problem with drug use? □ Yes □ No If yes, list type_____frequency_____

Do you exercise? □ Yes □ No If yes, list type_____ frequency_____

Do you have children? □ Yes □ No If yes, how many children?_____ | **Seatbelt usage?** List _____% of time worn

Have you been hit or threatened in the past year? □ Yes □ No

Employment history:

Are there cultural or religious beliefs to be considered in your care? □ Yes □ No **If yes, explain**_____

Potential barrier to learning: □ none □ inability to understand English □ Language (if other than English)_____
□ blind □ poor vision □ deaf □ decreased hearing □ unable to talk □ unable to read □ memory loss

Learns best by: □ reading □ verbal instruction □ practicing □ talking □ watching □ other

Do you have a: **Durable Power of Attorney** □ Yes □ No **If yes, list person(s)** _____
Healthcare representative? □ Yes □ No **If yes, list person(s)** _____
Living will? □ Yes □ No

Did you bring copies of above documents today? □ Yes □ No
Out of hospital Do Not Resuscitate (DNR) □ Yes □ No
Would you like information on any of the above? □ Yes □ No

FAMILY HISTORY Follow the lines across the page. Mark appropriate box.	**Alive & well**	**Deceased**	**Age at Death**	**Cause of Death**	**High blood pressure**	**Heart disease**	**High cholesterol**	**Diabetes**	**Cancer**	**Asthma/lung disease**	**Tuberculosis**	**Arthritis**	**Kidney disease**	**Glaucoma**	**Stroke**	**Migraine**	**Mental illness**	**Alcoholism**	**Bleeds easily**	**Anemia**	**Gout**	**Seizures**	**Other**
FATHER																							
□ GF □ GM																							
MOTHER																							
□ GF □ GM																							
□ BRO □ SIS																							
□ BRO □ SIS																							
□ BRO □ SIS																							
□ BRO □ SIS																							
□ Spouse																							

Additional Comments or Information: _____
_____
Person completing form: _____ Signature:_____ Date:_____

NO CHANGE SINCE PRIOR HQ Patient initials:_____ Date:_____