Southwest Family Physicians, Inc.

7225 Old Oak Blvd., Building A, Suite 210, Middleburg Hts., OH 44130

Name _____ Date

DOB _____

Comprehensive Adult New Patient Health History Questionnaire

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update form you can use. Please fill in all **seven** pages. It is long because it is comprehensive. We really want to know you well so we can properly care for you. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank-you!

Who referred you to my practice?

Circle one: patient, family member, physician, assigned. Name? _____

Main reason for today's visit: _____

Other concerns: _____

_____

What are your health goals for the next year? _____

How would you rate your health? (circle one): Excellent / Good / Fair / Poor

Please list healthcare providers & their specialty you see regularly: _____

_____

List any medical suppliers you use (e.g. respiratory supplies, etc): _____

MEDICATIONS: Please list (or show us your own printed record) **all** prescriptions and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc).

□ Check box if you do not take any prescription or over the counter medications.
□ Check box if you brought a list of your medications (give it to my assistant and don't write in medications below).

Medication	Dose (e.g. mg/pill)	How many times per day?

Name:_____ **DOB**_____

ALLERGIES or intolerance to medications? □ **NONE**

(If yes, to what & what reaction?) _____

IMMUNIZATIONS: Enter year (if known) of any vaccinations you have had.

Tetanus (Td)_____ With Pertussis (Tdap)_____ Varicella (Chicken Pox) shot *or* illness_____ Pneumovax (pneumonia) _____

Zostavax (shingles)_____ HPV _____

Influenza (flu shot)_____ Hepatitis A_____ Hepatitis B_____ MMR_____ Meningitis _____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) Date_____ Result, if known _____

Abnormal? □ No □ Yes

Sigmoidoscopy or Colonoscopy (circle one) Date (year)_____

Polyp? □ No □ Yes

Women only:

Mammogram Most recent date/where _____ Abnormal? □ No □ Yes

Pap Smear Most recent date/where _____ Abnormal? □ No □ Yes

Bone Density Test Most recent date/where _____ Abnormal? □ No □ Yes

Please do not write. Space intentionally left blank.

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Name:_____ DOB_____

PERSONAL MEDICAL HISTORY: Do you have now or have you had (past) any of the following conditions?

Condition	***Now***	***Past***	***Comments***
Alcohol / Drug abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder / Kidney Problems			
Blood Clot (leg)			
Blood Clot (lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer Breast			
Cancer Colon			
Cancer Other Type			
Cancer Ovarian			
Cancer Prostate			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema (COPD)			
Fractures (broken bones)			Where?
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Gout			
Gynecological Conditions (Endometriosis)			
Gynecological Conditions (Fibroids)			
Gynecological Conditions (Other)			
Heart Attack			
Hepatitis – Type A			
Hepatitis – Type B			
Hepatitis – Type C			
Hepatitis – Other			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease / Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate (enlargement)			
Prostate (nodules)			
Seizure / Epilepsy			
Skin Condition (Eczema)			

Personal History continued Name:_____ DOB_____

Condition	*Now*	*Past*	*Comments*
Skin Condition (Psoriasis)			
Skin Condition (Abnormal Moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid High (Overactive) / Hyperthyroidism			
Thyroid Low (Underactive) / Hypothyroidism			
Other (list)			
Other (list)			

□ **Check box if you have no history of significant medical illnesses.**

SURGICAL & PROCEDURE HISTORY – Please check off any procedure or surgeries. List any abnormal finding, details or complications under comments.

Surgical Procedure	*Code*	*Yes*	*Year*	*Comments*
Abdominal surgery				
Angiogram (heart)				
Angiogram (vascular)				
Appendectomy (appendix removal)				
Back surgery (lumbar)				
Biopsy (location in comments)				
Breast Biopsy				Circle: Right Left Both
Breast surgery				Circle: Right Left Both
Cataract surgery				
Colonoscopy				
Coronary Bypass				
Coronary Stent				
C-Section				
Echocardiogram (heart)				
EGD (Stomach Endoscopy)				
Gallbladder Removal				Circle: Laparoscopic
Heart Surgery (other than coronary bypass checked above)				
Hip Surgery				Circle: Right Left Both
Hysterectomy (partial, ovaries left)				Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (total, including ovaries)				Circle: Laparoscopic Vaginal Abdominal
Knee Surgery				Circle: Right Left Both
LEEP (Cervix surgery)				
Neck (Spine) surgery				
Ovary Removal				Circle: Right Left Both
Pulmonary Function Test				
Sigmoidoscopy				
Sinus Surgery				
Stress Test (stress echo)				
Stress Test (thallium/perfusion)				
Stress Test (treadmill)				
Tonsillectomy				
Tubal ligation				
Vasectomy				
Other (list)				

□ **Check box if you have never had any medical procedures or surgeries.**

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FAMILY HISTORY

Name:_____ DOB_____

Adopted? □No □Yes. If adopted and you do not know your family history skip the Family History section and continue to Health Issues on the next page.

Indicate which relative has had the following diseases (parents, brothers & sisters are the most important). Write in number of siblings in appropriate boxes.* If some siblings are alive and some are deceased use the space to the right to explain further.

	Mother	*Father*	** Sister(s)*	*Brother(s)*	*Mom's Mom*	*Mom's Dad*	*Dad's Mom*	*Dad's Dad*	
Alive									
Deceased									
Age currently or at death									

Diseases & Conditions	*Mother*	*Father*	*Sister(s)*	*Brother(s)*	*Mom's Mom*	*Mom's Dad*	*Dad's Mom*	*Dad's Dad*	*Other blood relatives (list relationship to you)*	*List age(s) at diagnosis if known and if this was the cause of death*
No significant history known										
Hypertension – high blood pressure										
Hyperlipidemia – high cholesterol										
Heart Attack, Angina (Coronary Artery Disease)										
Diabetes Type II (adult onset)										
Cancer, Breast										
Cancer, Colon										
Cancer, Prostate										
Osteoporosis										
Depression										
Alcoholism / Drug abuse										
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer, Lung										
Cancer, Ovarian										
Cancer, Other type										
Colon Polyp										
Diabetes Type I (childhood onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
Hip Fracture										
Hypothyroidism / Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Stroke										
Sudden Cardiac Death										
Other (list)										
Other (list)										

HEALTH ISSUES:

Tobacco Use:

Smoke or smoked cigarettes/ pipe/ cigars (circle)? □ Never □ Yes

Exposure to second hand smoke? □ No □ Yes

(If never used any tobacco can skip to Alcohol Use section below)

Current smoker: Packs/day: _____ # of years: _____

Former smoker: Quit date: _____

Approximately how many packs/day did you smoke? _____

How many years did you smoke? _____

Other tobacco? (circle) Snuff or Chew

Quit date _____ Currently use? □ Yes

Are you ready to quit? □ No □ Yes

Alcohol Use:

Do you drink alcohol? □ No □ Yes

# of drinks/week: _____ □ Beer □ Wine □ Liquor

How many times in a year have you had >3 drinks (for women) >4 drinks (for men) in a day? _____

Drug Use:

Have you **ever** used recreational drugs? □ No □ Yes

If yes, which ones? _____

Quit which ones? □ All _____

Any used currently? _____

Please continue to next column on right

Name: _____ DOB _____

Sexual Activity:

Are you sexually involved: □ Not currently □ Never □ Yes

Sexual partner(s) is/are/have been/may be in future: □ male □ female

Birth control method or STD prevention (check all that apply):
□ None needed □ Condom □ Pill □ IUD □ Patch □ Ring
□ Diaphragm □ Vasectomy □ Tubal ligation
□ Other method
(specify): _____

Other (ADL):

Military Service? □ No □ Yes

Blood Transfusion? □ No □ Yes

Exposure to toxic chemicals at work? □ No □ Yes

Exposure to toxic chemicals doing hobbies? □ No □ Yes

Diet:

Do you follow a special diet? □ No □ Yes

vegetarian, vegan, gluten free, other _____

Exercise: Do you exercise regularly? □ Yes □ No

If yes, what kind of exercise? _____

_____

How long (minutes)? _____ How often? _____

Do you use a helmet for recreational activities? (e.g. bike, skateboard, ski) □ Not applicable □ Yes □ No

Do you use seatbelts consistently? □ Yes □ No

In the past 2 weeks: Have you been feeling down, depressed or hopeless? □ No □ Yes

Do you have little interest or pleasure in doing things? □ No □ Yes

SAFETY:

Does your home have a working smoke detector? □ Yes □ No

Do you have guns in your home? □ No □ Yes

If yes, are they locked up & ammo stored separately? □ Yes □ No

Have you or any family members ever been hurt, insulted, threatened or screamed at? □ No □ Yes

SOCIAL DOCUMENTATION:

Name you prefer we use when contacting you (nickname, first, or last with Mr, Mrs, Ms, etc): _____

Country of birth: _____

Who lives at home with you: □ No one □ Spouse/partner □ Children _____

□ Pets (what type) _____ □ Other (roommates, extended family, etc) _____

Please list your interests, hobbies, group involvement, volunteer work, and/or travel outside of country in the past 6 months:

_____

_____

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Name:_____ DOB_____

SOCIOECONOMIC:

Occupation (or prior occupation): _____

Employer: _____

If you are not currently working, you are: □ retired □ unemployed □ on a leave of absence □ disabled □ homemaker □ other _____

Marital status: □ single □ partner □ married □ divorced □ widowed

Spouse/partner's name: _____

Number of children:_____Ages (if minors):_____#of grandchildren:_____#of great grandchildren: _____

Education: □ high school or GED □ trade school □ college □ graduate school □ other _____

MEDICAL FORMS:

Please check any of the following forms you have completed:

- □ Advance Directive for Health Care (ADHC)
- □ Durable Power of Attorney (DPA) for healthcare decisions
- □ Living Will
- □ POLST (Physician Orders for Life Sustaining Therapy)
- □ Know about these or have the forms but have not completed them
- □ Don't know what these are

WOMEN HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____ Number of abortions: _____

Age at beginning of periods (menstruation): _____

Age at end of periods (menopause/hysterectomy): _____ □ Not applicable

Do you have concerns about your periods or menopause you'd like to discuss? □ No □ Yes

If you are having periods, how often do they occur? Every_____days. How long do they last?_____days.

Thank-you for taking the time to complete this form!