BRIEF HEALTH QUESTIONNAIRE

Patient's Name ____ Age ______ DOB: _______________

Reason for today's visit: ____

SURGICAL HISTORY

Please put a check next to the surgery and fill in the year you had that surgery. If you have NOT had any surgeries, check NONE.

Type	Year	Type	Year
( ) Appendix	_______	( ) Mastectomy	______
( ) Gallbladder	_______	( ) Hysterectomy with ovaries removed	______
( ) Tonsillectomy	_______	( ) Hysterectomy without ovaries removed	______
( ) PE Tubes	_______	( ) Tubal Ligation	______
( ) Heart Bypass	_______	( ) Colon Surgery	______
( ) Balloon Angioplasty	_______	( ) Splenectomy	______
( ) Balloon Angio/stent	_______	( ) Knee Surgery	______
( ) Valve Replacement	_______	( ) Disc Surgery	______
( ) Artery Bypass	_______	( ) Prostate Surgery	______
		( ) Vasectomy	______
		( ) Organ Transplant	______

( ) NONE

Other ____

HOSPITALIZATIONS (OTHER THAN pregnancy and surgeries above)

Please put a check next to the hospitalization (OVERNIGHT stays only) and fill in the year of that hospitalization. If you have NOT been hospitalized, please check NONE.

	Details	Year		Details	Year
( ) Abdominal pain	________________________	_______	( ) Fracture	________________________	______
( ) Chest Pain	________________________	_______	( ) Pneumonia	________________________	______
( ) Dehydration	________________________	_______	( ) Viral Illness	________________________	______
( ) Other	________________________	_______	( ) Other	________________________	______
( ) NONE					

OTHER MEDICAL HISTORY

Have you had or do you have any of the following? Please give year diagnosed. If none, check NONE.

	Year Diagnosed		Year Diagnosed
( ) Diabetes	______	( ) Seizure Disorder	______
( ) High Blood Pressure	______	( ) Thyroid Disease	______
( ) High Cholesterol	______	( ) Tobacco Use	______
( ) Atrial Fibrillation	______	( ) Asthma	______
( ) Coronary Artery Disease	______	( ) Emphysema	______
( ) Congestive Heart Failure	______	( ) Allergic Rhinitis	______
( ) Acid Reflux	______	( ) Anxiety	______
( ) Irritable Bowel Syndrome	______	( ) Depression	______
( ) Migraine	______	( ) Attention Deficit	______
( ) Osteoarthritis	______	( ) Gout	______

( ) NONE

Other ____

CURRENT MEDICATIONS

Please list any and all medications, vitamins, or supplements that you are presently taking regularly or from time to time. If none, please state "none".

Drug Name	mg	How often?	Regularly or as needed	Drug Name	mg	How often?	Regularly or as needed

Please continue on next page

PHARMACY INFORMATION

Preferred Pharmacy: ___________________________________ Location: ____

MEDICATION ALLERGIES

If you are allergic to any medication(s), please list them. Give Name of medication and type of reaction (Rash, Shock, Respiratory problems, GI upset, Diarrhea, Unknown, Childhood, Other). If none, please state "none".

FAMILY HISTORY

Put a check next to the disease and circle the family member (M = Mother, F = Father, B/S = Brother or Sister, GP = Grandparent) who has had this disease. If you are adopted, please so indicate.

( ) **Adopted**

( ) Breast Cancer M S GP
( ) Colon Cancer F M B/S GP

( ) Diabetes F M B/S GP
( ) Heart Disease F M B/S GP

( ) Melanoma * F M B/S GP
( ) Ovarian Cancer M S GP
( ) Prostate Cancer F B GP

*This is a serious type of skin cancer that spreads and **not** the regular, more common skin cancer varieties.

SOCIAL HISTORY

In order to know you better, please fill out the information below.

Marital Status: ________
Occupation:__________________
# of Children: ________

Birthplace (State/Country): _____________
Year Moved To Area: ________
from __________________

Tobacco Usage (Amount):_______
Drinks per day: ____________
Exercise: _____ /week.

The Federal Drug Administration (FDA) suggests that doctors document a patient's race/ethnicity according to the following categories. This is being requested in that some medications may be better for (or, perhaps, harmful to) certain groups. Please specify by checking one (or more, if that better clarifies your heritage) of the following:

Hispanic / Latino ____
Black / African American ____

Native Hawaiian/Pacific Island _____
Am. Indian /Alaska Native _____

Asian ____
White ____

HEALTH MAINTENANCE

When was your last complete physical? _________________ (month/year)
When was your last tetanus booster? (recommended every ten years) _______________ (month/year)
If over the age of 60, have you received the Zostavax (shingles) vaccine? Yes No Date of vaccine __________ (month/year)
If over the age of 65, have you received the pneumonia vaccine? Yes No Date of vaccine __________ (month/year)
Do you have a "living will"? Yes No Date last reviewed ____________ (month/year)

IF OVER AGE 50

When did you last have
A stool specimen tested for blood/cancer? (Recommended yearly) _________________ (month/year)
A "scope" exam of the colon for cancer? (Recommended every five years) _________________ (month/year)
A treadmill exercise stress test? _________________ (month/year)
An EKG _________________ (month/year)

FOR MEN OVER 50

When was your last PSA performed? _________________ (month/year)

FOR WOMEN ONLY

When was your last mammogram? _____________ (month/year)
When was your last Pap smear? _____________ (month/year) Performed by: ___________________________
For women over age 50, when was your last bone density study? ___________________________ (month/year)

_______________________________________ ______________
Signature Date

(Rev: bcf 05.23.11)