ESTABLISHED Patient
BRIEF Health Questionnaire
UPDATE

Patient Name ______________________________ DOB: ___________ Today's Date: ________________

As your family physician it is important that we regularly review your medical history to be certain that it is as up-to-date as possible. We know that you have previously provided us with your past medical history. The following few questions relate to those items in your history, **which may have changed since you last updated our records (either at your first visit or since your last physical).**

Please list any **surgery and approximate date** you have had since you last updated our records (either at your first visit or since your last physical.) (If none, please indicate "none".)

Please list any **hospitalizations and approximate date** (**OVERNIGHT** stays only) you have had since you last updated our records (either at your first visit or since your last physical.). (If none, please indicate "none".)

Please list any **physicians** you have consulted since you last updated our records (either at your first visit or since your last physical.). Please also include the **diagnosis (or problem)** for which you were seen. (If none, please indicate "none".)

Please list below any **medications** you take regularly or from time-to-time. If you do not know the names of the medications (or if you have a long list of medications), we will gladly review this with you verbally, comparing that to the list of recently prescribed medications we have in your current chart. (If none, please indicate "none".)

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

We always want to double check on **medication allergies** and ask that you please list those again for us here. (If none, please indicate "none".)

Please continue on next page

Patient Name ______________________________

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.

( ) Adopted

( ) Breast Cancer M S GP	( ) Diabetes F M B/S GP	( ) Melanoma * F M B/S GP
( ) Colon Cancer F M B/S GP	( ) Heart Disease F M B/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

Please also update the following information:

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

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

Smoking (packs/day):_______
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 _____

Update the following information only if they have been done at facilities other than Panther Creek Medical Center/Village Medical Center.

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 09.07.09)