BRIEF HEALTH QUESTIONNAIRE

Patient's Name _____ **Age** _____ **DOB:** _____

Reason for today's visit: _____

Preferred Method of Contact: **( ) Email** **( ) Phone** **( ) Letter**

PHARMACY INFORMATION

Preferred Pharmacy: _____ **Location:** _____

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	_____
( ) Tonsillectomy	_____	( ) Tubal Ligation	_____
( ) PE Tubes	_____	( ) Colon Surgery	_____
( ) Heart Bypass	_____	( ) Splenectomy	_____
( ) Balloon Angioplasty	_____	( ) Knee Surgery	_____
( ) Balloon Angio/stent	_____	( ) Disc Surgery	_____
( ) Valve Replacement	_____	( ) Prostate Surgery	_____
( ) Artery Bypass	_____	( ) 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

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, PGF = Paternal Grandfather, PGM = Paternal Grandmother, MGF = Maternal Grandfather, MGM = Maternal Grandmother) who has had this disease.

( ) Breast Cancer: F M B/S PGF PGM MGF MGM
( ) Melanoma *: F M B/S PGF PGM MGF MGM
( ) Heart Disease: F M B/S PGF PGM MGF MGM
( ) Prostate Cancer: F B PGF MGF
( ) Diabetes: F M B/S PGF PGM MGF MGM
( ) Colon Cancer: F M B/S PGF PGM MGF MGM
( ) Ovarian Cancer: M S PGM MGM
( ) Adopted

*****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: _____ Birthplace (State/Country): _____ Alcoholic drinks per day: _____
Occupation:_____ Year Moved To Area: _____ Exercise: _____ /week for _____ minutes
# of Children: _____ from _____

Smoking Status
( ) current every day smoker ( ) current some day smoker ( ) former smoker ( ) never smoker ( ) unknown if smoked

Tobacco Usage (leave blank if N/A)
( ) Cigarettes ( ) Cigars ( ) Smokeless Tobacco

Cigarettes (pack-per day – leave blank if N/A) _____

Cigars (per week – leave blank if N/A) _____

Smokeless (cans – leave blank if N/A) _____

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)

DEPRESSION SCREENING (12 YRS +)

1. During the past two weeks, have you often been bothered by feeling down, depressed, or hopeless?
( ) not at all ( ) several days ( ) more than half the days ( ) nearly every day

2. During the past two weeks, have you often been bothered by little interest of pleasure in doing things?
( ) not at all ( ) several days ( ) more than half the days ( ) nearly every day