

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, vitamins, or supplements** 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".)

<u>Drug Name</u>	<u>mg</u>	<u>How often?</u>	<u>Regularly or as needed</u>	<u>Drug Name</u>	<u>mg</u>	<u>How often?</u>	<u>Regularly or as needed</u>

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".)

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.

- | | |
|--|--|
| <input type="checkbox"/> Breast Cancer: F M B/S PGF PGM MGF MGM
<input type="checkbox"/> Melanoma*: F M B/S PGF PGM MGF MGM
<input type="checkbox"/> Heart Disease: F M B/S PGF PGM MGF MGM
<input type="checkbox"/> Prostate Cancer: F B PGF MGF | <input type="checkbox"/> Diabetes: F M B/S PGF PGM MGF MGM
<input type="checkbox"/> Colon Cancer: F M B/S PGF PGM MGF MGM
<input type="checkbox"/> Ovarian Cancer: M S PGM MGM
<input type="checkbox"/> Adopted |
|--|--|

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

Please continue on other side

SOCIAL HISTORY

Please also update the following information:

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) _____

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)

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

Signature

Date