Mayer and Cope Family Practice **Date:**

Comprehensive Adult Patient Health History Questionnaire

Your answers on this form will help us get an accurate history or update of your medical concerns and conditions. Please fill in all 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 estimate. If you are uncomfortable with any question, do not answer it. Your responses are confidential. Thank-you!

Who referred you to our practice?

Circle one: patient family member,

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: _____

_____

_

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?

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

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(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) _____ Prevnar-13 (pneumonia) _____Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____ MMR _____ Meningitis _____ Zostavax (shingles) _____ HPV _____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) Date _____ Result, if known _____
Colonoscopy Date (year)_____ Polyp(s)? □ No □ Yes

Women only:
Mammogram Most recent date/where _____
Pap Smear Most recent date/where _____
Bone Density Test Most recent date/where _____

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			
Heart Attack			
Hepatitis – A, B, or C			
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)			

Skin Condition (Psoriasis)			
Skin Condition (Abnormal Moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid High (Overactive)			
Thyroid Low (Underactive)			
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	***Yes***	***Year***	***Comments***

Mayer and Cope Family Practice **Name:** **DOB:**

Abdominal surgery			
Angiogram (heart)			
Angiogram (vascular)			
Appendectomy (appendix removal)			
Back surgery (low back)			
Biopsy (location in comments)			
Blood Transfusion			
Breast Biopsy			Right Left Both
Breast surgery			Right Left Both
Cataract surgery			
Coronary Bypass			
Coronary Stent			
C-Section			
EGD (Stomach Endoscopy)			
Gallbladder Removal			
Heart Surgery (other than coronary bypass checked above)			Circle: Laparoscopic
Hernia Surgery			Circle: Inguinal-groin Abdomen
Hip Surgery			
Hysterectomy (partial, ovaries left)			Circle: Right Left Both
Hysterectomy (total, including ovaries)			Circle: Laparoscopic Vaginal Abdominal
Knee Surgery			Circle: Laparoscopic Abdominal Vaginal
LEEP (Cervix surgery)			Circle: Right Left Both
Neck (Spine) surgery			
Ovary Removal			
Pulmonary Function Test			Circle: Right Left Both
Sinus Surgery			
Stress Test (treadmill)			
Tonsillectomy			
Tubal ligation (female sterilization)			

Vasectomy (male sterilization)			
Other (list)			

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

FAMILY HISTORY

Adopted? □ **No** □ **Yes.** **If adopted and you do <u>not</u> 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).

Mayer and Cope Family Practice **Name:** **DOB:**

	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:

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

Birth control method or STD prevention (check all that apply): □ None needed

Mayer and Cope Family Practice **Name:** **DOB:**

□ Condom □ Pill □ Vasectomy □ Tubal ligation □ IUD □ Patch □ Ring □ Natural Family Planning

Tobacco Use: (If never used any tobacco can skip to Alcohol Use section below)
Smoke or smoked cigarettes/ pipe/ cigars (circle)?

Exposure to second hand smoke? □ No □ Yes

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? _____

Depression Screen:

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 or threatened? □ No □ Yes

Exposure to toxic chemicals at work? □ No □ Yes

Do you use a helmet for recreational activities? □ No □ Yes

Mayer and Cope Family Practice **Name:** **DOB:**

SOCIAL:

Name you prefer we use when contacting you _____
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: _____

_____

Occupation (or prior occupation): _____

Employer: _____
If you are not currently working, you are:

□ retired □ unemployed □ on a leave of absence □ disabled □ homemaker □ student

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 _____

Military Service? □ Yes □ No If Yes give details:

Spiritual:

Do you have spiritual beliefs that help you cope with stress? □ Yes □ No

Are you part of a spiritual or religious community? □ Yes □ No

If yes name:

Exercise: Do you exercise regularly? □ Yes □ No
If yes what kind of exercise _____

How long (minutes)? _____ How often? _____

Diet: Do you follow a special diet? vegetarian, vegan, gluten free, other _____

MEDICAL FORMS:

Please check any of the following forms you have completed:

- □ Advance Directives
- □ Durable Power of Attorney for healthcare decisions
- □ Living Will
- □ MOLST (Medical Orders for Life Sustaining Therapy)
- □ Know about these or have the forms but have not completed them
- □ Don't know what these are

WOMEN'S 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!