HEALTH QUESTIONNAIRE

Name: _____ Date: _____

Birthdate: _____ PCP: _____

For ***Established Patients*** , please review and **only** note any ***changes*** since you last completed our form.

Medications *Use the back of this form for more space:*

Please list any medications that you currently take regularly (including non-prescription medications, vitamins, or supplements) and the Strength and Dosing;(If prescribed by someone other than Irvine Family Care, please list that doctor's name)

Allergies

Please list any allergies to medications, foods or other, and the kind of reaction you had to each, and your age at the time

Illnesses/Conditions

Do you have or have you ever had any of the following:

	Note type of/ kind of:	Age diagnosised
_____	Anemia	_____
_____	Anxiety /Panic Attacks/ Phobias	_____
_____	Arthritis / Rheumtoid processes	_____
_____	Asthma / Allergic rhinitis	_____
_____	Birth Defects	_____
_____	Cancer: type:	_____
_____	Colitis	_____
_____	Concussion	_____
_____	Depression / Suicidal thoughts	_____
_____	Diabetes	_____
_____	Emphysema	_____
_____	Heart Attack/Heart Disease	_____
_____	High Blood Pressure	_____
_____	High Cholesterol	_____
_____	Kidney Disease	_____
_____	Liver Disease	_____
_____	Low Blood Sugar	_____
_____	Mitral Valve Prolapse/Murmur	_____
_____	Osteoporosis	_____
_____	Pneumonia	_____
_____	Rheumatic Fever	_____
_____	Seizure Disorder	_____
_____	Sexually Transmitted Disease	_____
_____	Stroke	_____
_____	Thyroid Disorder	_____
_____	Tuberculosis	_____
_____	Ulcer	_____

Surgical Procedures/Hospitalizations Year

If you know, note the name of surgeon

_____ _____

_____ _____

_____ _____

_____ _____

Serious Injuries

_____ _____

_____ _____

_____ _____

Childhood Diseases Year

_____ Chickenpox _____

_____ Measles _____

_____ Mumps _____

_____ Polio _____

_____ Other: _____ _____

Gynecological History (women only)

Are you pregnant? _____

Are you breast feeding? _____

First Day of your Last menstrual period: _____

How many pregnancies have you had? _____

How many children do you have? _____

How many miscarriages have you had? _____

At what age did you start having periods? _____

Have you ever had an abnormal Pap? _____

Have you had HPV? _____

Have you had the HPV vaccine? Dates: ___/___/___

Family History

Has any blood relative ever had any of the following : Note if **M** (mother's side) or **P** (paternal- father's side) and **Age**

Relative (mother, father, sister, aunt, grandmother etc.)	**Age**
Anaesthesia Complications:	
Bleeding problems	
Cancer: type	
Diabetes	
Heart Attack or Disease	
Alcoholism/ Drug Abuse	
High Blood Pressure	
Mental Illness/Anxiety / Suicide	
Seizures/Neurological Diseases	
Stroke	
Other	

	Living Age	Deceased Age (at death) & cause
Father		
Mother		
Brother / Sister		
Husband / Wife		
Son / Daughter		

Continued on other side →

Health Quesionnaire continued Name: _____ Date:_____

For ***ESTABLISHED*** Patients:You only need to ***Update*** us

When, if ever, did you last have any of the following:

Cholesterol check	_____	Pap Smear	_____
Colonoscopy	_____	Prostate exam	_____
EKG/Cardiogram	_____	Tetanus (Last shot)	_____
Mammogram	_____	Treadmill stress test	_____

Social History

Are you married? **Yes / No** Living with a partner? **Yes / No**
Have you ever felt unsafe or abused, either physically or emotionally? **Yes / No** Currently? **Yes / No**
Do you have children / dependents at home? *Names & birthdates:* _____
Are you employed? **Yes/ No** *What field?* _____ _____
What is your highest level of education? _____
Do you or have you ever smoked or chewed tobacco? **Yes / No**
Packs per day _____ */ yrs* _____ *Quit?* _____ *When?* _____
Do you or have you ever used illegal drugs? **Yes / No** *Type:* _____
Do you drink alcohol? **Yes / No** *What kind?* _____ *How much per week?* _____
Have you been exposed to toxic substances? **Yes / No** *What?* _____
Do you drink caffeine daily? **Yes / No** *How much?* _____
Do you wear seat belts? **Yes / No**
Do you use car seats for your children if under 60lbs.? **Yes / No**
Do you have a living will or advance directives? **Yes / No**
No matter how old you are, you should consider having an advanced directive on file with us
You can print out a copy from our website: **irvinefamilycare.com**

We want to emphasis that ***REGULAR EXERCISE*** *is one of the most important things you can do to maintain your health!* What kind are you currently doing? _____ *How often?* _____

Review of Symptoms **Please circle any of the following that you are experiencing**

General Fatigue Fever Hopelessness Hot flashes Insomnia Night sweats Poor concentration Recent weight loss or gain Loss of interest in usual activities Depression Anxiety

Skin Change in pigmentation Eczema Hives Jaundice Rashes

ENT Change in vision / hearing Dizziness Englarged glands Glaucoma Headaches Hearing loss Neck stiffness Nose bleeds Chronic sinus or ear problems

Respiratory Asthma Difficulty breathing Frequent colds / coughing Shortness of breath Spitting up blood.

Cardiac Angina Chest pain Difficulty walking 2 blocks Heart murmur High blood pressure Palpitations Swelling of hands / feet

Gastrointestinal Abdominal pain /cramping Blood or dark stool Change in bowel habits Frequent diarrhea Frequent indigestion / heartburn / gas / bloating Hepatitis Hemorrhoids Vomiting blood

Genitourinary Difficulty urinating Frequent urination Loss of bladder control Unsatisfactory sex life

Musculoskeletal Joint pain or swelling Difficulty walking Muscle cramping or weakness Varicose veins

Neuropsychiatric Prior treatment for depression / psychiatric care? Fainting spells Paralysis Convulsions

Hematologic Easy bruising Excessive bleeding after cuts Slowing healing after cuts

Anything else you want us to know?