Health Screening Questionnaire

Date _____

(to be completed prior to your first visit at Three Rivers Family Medicine)

Name _____ Age _____

Address _____ Birth date _____

_____ Place of Birth _____

City_____State_____ Marital Status _____

Home Telephone _____ Work Telephone _____

Male ❒ Female ❒

Education: High School ❒ College ❒ Graduate Degree ❒

Part 1 - Health History

Are you having any medical problems that need to be discussed?

Please list them:

_____

_____

_____

What medications do you take regularly?

(Include prescriptions, vitamins, birth control pills and over the counter medicine)

Medication	Dose	Medication	Dose
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Medication Allergies	Type of Reaction
1._____	_____
2._____	_____
3._____	_____

Have you ever been told by a doctor that you have the following problems?

	Yes	No
High Blood Pressure	❒	❒
Heart Attack	❒	❒
Angina	❒	❒
Stroke	❒	❒
High Cholesterol	❒	❒
Heart Failure (water in lungs)	❒	❒
Asthma or Emphysema	❒	❒
Tuberculosis/Valley Fever	❒	❒
Diabetes	❒	❒
Thyroid Disease	❒	❒
Seizures	❒	❒
Migraine headache	❒	❒
Psychiatric Problem/ Depression	❒	❒
Liver Disease/Hepatitis	❒	❒
Alcoholism	❒	❒
Ulcers	❒	❒
Anemia	❒	❒
Cancer	❒	❒
Other	❒	❒

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Operations? (please include approximate dates)

_____ _____

_____ _____

_____ _____

Hospitalizations and other medical conditions? (please include approximate dates)

_____

_____

_____

Radiation Treatments/Chemotherapy? (please include approximate dates and number of treatments)

_____

_____

_____

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PART 3 - LIFE-STYLE HABITS

Tobacco	Yes	No
Do you use any kind of tobacco?	❒	❒
Type, amount, and how many years? _____		
Have you ever used tobacco in the past?	❒	❒
If yes, how much and for how long?_____		
When did you quit? _____		
Alcohol		
Do you drink alcohol?	❒	❒
Do you have more than two alcoholic drinks per day?	❒	❒
Drugs		
Do you or have you ever used street drugs?	❒	❒
If yes, when and what do you use? _____		
Sexually Transmitted Diseases (STD) AIDS/HIV		
Have you ever:		
Had an HIV test	❒	❒
Had more than one sexual partner in the last 10 years?	❒	❒
Had a sexually transmitted disease?	❒	❒
Lead a Gay or Bisexual Life-style?	❒	❒
Had a blood transfusion before 1985?	❒	❒
Exercise		
Do you have an exercise program?	❒	❒

Type _____

Minutes _____

Frequency _____

PART 4 - FAMILY MEDICAL HISTORY

Please list family members with significant health problems

Relationship	Living?	Age	Medical Problems	Cause of Death/Age
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do you have any family history of : ❒diabetes ❒glaucoma ❒hypertension ❒thyroid disease ❒heart disease ❒hemachromatosis

❒breast, colon or prostate cancer ❒other cancers specify:_____

PART 5 - HEALTH MAINTENENCE

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Immunizations

Do you know the date of your last :	Yes	No
Tetanus Vaccine	Date: _____	
Pneumonia Vaccine	Date: _____	
Tuberculosis (TB) Skin Test?	Date: _____	
Have you ever had a positive reaction to a TB skin test?	❒	❒
Were you treated for this reaction?	❒	❒
H/O Chicken Pox or vaccination for same		

Colon Screening

Date of last Sigmoidoscopy/Colonoscopy: _____

Findings: _____

Women Only

Do you examine your breasts each month?	❒	❒
Have you ever has an abnormal Pap Smear?	❒	❒
Date of last Pap Smear: _____		
Date of last Mammogram: _____		
Have you noticed any unusual lumps in your breasts?	❒	❒
Blood or discharge from your nipples?	❒	❒
Do you bleed between periods, or since going through menopause?	❒	❒

How many children do you have? _____

How many pregnancies have you had? _____

Last normal period? _____

Have you had a hysterectomy?

Why? _____

Have you ever taken hormones?

If so, are you still taking them? Yes❒ No❒ If not, why not? _____

Have you ever had a DEXA Scan? (Bone Density study for Osteoporosis) Yes❒ No❒ Year of Test _____

Findings _____

Men Only	Yes	No
Do you examine your testicles monthly?	❒	❒

Age 65 or over

Safety

Do you or your family think you have memory problems?	❒	❒

How many times have you fallen in the past six months? _____

Review of Systems

PART 2 - Are you currently having any of the following problems?

Head	**Yes**	**No**
Severe, persistent or migraine headaches?	❒	❒
Eye disease other than the need for glasses?	❒	❒
Unusual trouble swallowing food or water?	❒	❒
Persistent hearing loss?	❒	❒
Chest		
Persistent shortness of breath?	❒	❒
New or persistent cough?	❒	❒
Coughing up blood?	❒	❒
Unusual or severe chest pain of chest pressure?	❒	❒
Frequent or persistent palpitations?	❒	❒
Abdomen		
Persistent abdominal pain or heartburn?	❒	❒
Vomited blood (red or black?)	❒	❒
Black or red stools?	❒	❒
Diarrhea or frequent bowel movements?	❒	❒
Severe constipation?	❒	❒
Sleep		
Has anyone ever told you that you stop breathing when you sleep?	❒	❒
Joints/Spine		
Painful or swollen joints?	❒	❒
Kidney and Bladder		
Painful urination?	❒	❒
Do you get out of bed more than two times at night to urinate?	❒	❒
Loss of bladder control?	❒	❒
Men only		
Prostate problems?	❒	❒
Changes or decrease in the stream of urine?	❒	❒
General		
Unexplained weight loss/gain?	❒	❒
Night sweats?	❒	❒
Recurrent fevers?	❒	❒

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