HEALTH QUESTIONNAIRE
Confidential Data

INDIANA INTERNAL MEDICINE CONSULTANTS – INDIANA PRIMARY CARE ASSOCIATES
CENTER FOR RESPIRATORY & SLEEP MEDICINE – INDIANA INFECTIOUS DISEASE CONSULTANTS

Name **D.O.B.** **Date**

Reason for visit and symptoms

LIST OTHER MEDICAL PERSONNEL INVOLVED IN CARE AND THE REASON		
Name	**Phone number**	**Reason**

ALLERGIES/INTOLERANCES			
Allergen Name	**Reaction**	**Intolerance or Allergy**	**Start Date**
		□ Intolerance □ Allergy	
		□ Intolerance □ Allergy	
		□ Intolerance □ Allergy	
		□ Intolerance □ Allergy	

MEDICATIONS - List <u>all</u> prescription medications you currently take.				
Medication	**Start Date**	**Strength**	**How Often**	**Reason**
SUPPLEMENTS - List <u>all</u> vitamins, hormones, alternative remedies or over the counter medications you use.				
Supplement	**Start Date**	**Strength**	**How Often**	**Reason**

PREVENTATIVE CARE - List date of last test or screening	
Test	**Date of last test or screening**
Colonoscopy	
Gastroscopy	
Dental examination	
DEXA (bone density)	
Eye Exam	

MALE PATIENTS	**Date of last test**	**Please ✓ check below if applicable.**
PSA laboratory		□ Urethral discharge
Rectal/prostate exam		□ Urinary: decreased flow or delayed flow/ejaculation
Testicular exam		□ Problems achieving/maintaining erection
		□ Diminished libido

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FEMALE PATIENTS	**Date of last test**	**Menstrual History**
Breast examination		Age of onset _____ Date of last period:_____ □ regular □ irregular
Mammogram		Flow: □ Heavy □ Mod □ Light □ Pain/cramps w/menstrual flow Days of flow:_____ Length of cycle:_____
Pap smear		No. of pregnancies_____ Live births_____ Miscarriages_____ Birth control method_____ Age of menopausal onset_____
Rectal examination		□ Pain after intercourse □ Bleeding after intercourse
		□ Flushing /Menopause □ Diminished libido □ Infertility/infertility problems □ Problems_____

HEALTH HISTORY - Are you being treated for or have you ever had any of the following health conditions?
Please ✓ check if applicable. Additional space is provided below for details or other health conditions not listed.

Allergies	Colitis	*Defibrillator*	Nervous system disease
Alcohol problems	Constipation	*Failure*	Osteoporosis/osteopenia
Anemia	COPD	*Pacemaker*	Obesity
Aneurysm	Dementia	*Palpitations*	Peptic ulcer(s)
Anxiety	Depression	*Stents*	Peripheral vascular disease
Arthritis:	Diabetes	*Valvular disease*	Pleurisy
Osteoarthritis	*Last: HgA1 C #_____*	Hemorrhoids	Pneumonia
Degenerative	*Dilated eye exam_____*	Hepatitis A B C other____	Prostate problems
Psoriatic	*Urine for microalbumin _____*	High blood pressure	Seizure disorder
Rheumatoid	Diarrhea	HIV/AIDS	Sexually transmitted disease(s)
Asthma	Diverticulosis/diverticulitis	Hyperthyroidism	Sleep apnea
Atrial fibrillation	Eating disorder	Hypothyroidism	Stroke
Bleeding problem	Emphysema	Irritable bowel	TIA
Blood clots	Fertility issues	Kidney disease	Tremors
Blood transfusion	GERD	Kidney failure	Tuberculosis
Bronchitis	Glaucoma	Kidney stones	Urinary:
Cancer	Goiter	Low back pain	*Frequency*
Type _____	Gout	Lupus (SLE)	*Incontinence*
CHF	Headaches	Mental illness/mood disorder_____	*Infection(s)*
□ *systolic* □ *diastolic*	Heart	MRSA infection(s)	*Retention*
Ejection fraction _____	*Arrhythmia*	Narcolepsy	Varicose veins
Crohn's disease	*CAD (MI)*	Neuropathy	Weight problems

List additional information and other health conditions not listed above:

_____

_____

_____

PAST PROCEDURES/SURGERIES - List surgical procedures, reasons for hospitalizations and the year.

Type	Approximate Date	Type	Approximate Date

IMMUNIZATIONS - List date of last injection and if record is attached

INJECTION	DATE	RECORD ATTACHED?	INJECTION	DATE	RECORD ATTACHED?
Gardasil		□ Yes □ No	**Pneumonia**		□ Yes □ No
Hepatitis A		□ Yes □ No	**Polio**		□ Yes □ No
Hepatitis B		□ Yes □ No	**Tetanus**		□ Yes □ No
Influenza		□ Yes □ No	**T-dap**		□ Yes □ No
MMR		□ Yes □ No	**Typhoid**		□ Yes □ No
Meningitis		□ Yes □ No	**Zostavax**		□ Yes □ No

SOCIAL HISTORY

Smoking Status □ Current every day smoker □ Current someday smoker □ Former smoker □ Never smoker
□ Smoker, current status unknown

If Current or Quit within 12 months, □ Cigarettes □ Cigars □ Pipe □ Smokeless **Amount?** _____ **Duration?**_____

If Current or Quit within 12 months, Smoking Cessation Counseling? □ Yes □ No If yes, list date of counseling: _____

Preferred Language: _____ **Ethnicity:** □ Hispanic or Latino □ Not Hispanic or Latino

Race: □ White □ African American □ American Indian/Alaskan □ Asian □ Hawaiian/Pacific Islander □ Other

Relationship status: □ Married □ Single □ Widowed □ Divorced □ Partnered □ Other

How do you identify your sexual orientation? □ Heterosexual(opposite sex partner) □ Gay/lesbian(same sex partner) □ Bisexual
□ Transgender – If Transgender, how would you like to be addressed? _____

Alcohol? □ Yes □ No □ Rarely Amount _____ per day/wk/mos. | **Caffeine?** □ Yes □ No _____cups per day/wk/mos.

Do you/or have you had a problem with drug use □ Yes □ No If yes, list type_____frequency_____

Do you exercise? □ Yes □ No If yes, list type_____frequency_____

Do you have children? □ Yes □ No If yes, how many children?_____ | **Seatbelt usage?** List _____% of time worn

Have you been hit or threatened in the past year? □ Yes □ No

Employment History:

Are there cultural or religious beliefs to be considered in your care? □ Yes □ No If yes, explain _____

Potential barrier to learning: □ none □ inability to understand English □ Language (if other than English) _____
□ blind □ poor vision □ deaf □ decreased hearing □ unable to talk □ unable to read □ memory loss

Learns best by: □ reading □ verbal instruction □ practicing □ talking □ watching □ other

Do you have a : **Durable Power of Attorney?** □ Yes □ No **If yes, list person(s)** _____
Healthcare representative? □ Yes □ No **If yes, list person(s)** _____
Living Will? □ Yes □ No **Out of hospital Do Not Resuscitate (DNR)** □ Yes □ No

Did you bring copies of above documents with you today? □ Yes □ No **Would you like information on any of the above?** □ Yes □ No

FAMILY HISTORY Follow lines across the page. Mark appropriate box.	Alive & well	Deceased	Age at Death	Cause of Death	High blood pressure	Heart disease	High cholesterol	Diabetes	Cancer	Asthma/lung disease	Tuberculosis	Arthritis	Kidney disease	Glaucoma	Stroke	Migraine	Mental illness	Alcoholism	Bleeds easily	Anemia	Gout	Seizures	Other
FATHER																							
□ GF □ GM																							
MOTHER																							
□ GF □ GM																							
□ BRO □ SIS																							
□ BRO □ SIS																							
□ BRO □ SIS																							
□ BRO □ SIS																							
□ SPOUSE																							

Additional Comments or Information:

_____

Person completing form **Signature** **Date**