Health Assessment Questionnaire

Patient Name: _____ Date: _____

DOB: _____ Age: _____ Sex Assigned at Birth: ☐ M ☐ F New Patient: _____ Established Patient: _____

MEDICAL INFORMATION

Name of Primary Care Physician: _____ Phone: _____

Physician Address: _____ Fax: _____

Date of last visit with primary care physician: _____ Reason: _____

Preferred Hospital: ☐ Ft. Hamilton Hughes ☐ Mercy –Fairfield ☐ Middletown Regional ☐ Butler Bethesda ☐ _____

Do you have Advance Directive(s) in place (i.e. living will, power of attorney) ☐ Yes ☐ No Type: _____

Allergies: Are you allergic to any drugs? ☐ Yes ☐ No If yes, please list: _____

Do you have any food allergies? ☐ Yes ☐ No If yes, please list: _____

Please check if you are experiencing any of the following or have within the past year:

Conditional (General)

☐ Yes ☐ No Recent weight change
☐ Yes ☐ No Fatigue
☐ Yes ☐ No Other

Eyes and Vision

☐ Yes ☐ No Wear glasses/contact lenses
☐ Yes ☐ No Blurred or double vision
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Eye injury or disease

Ears, Nose, Throat

☐ Yes ☐ No Bleeding gums
☐ Yes ☐ No Bad breath or bad taste
☐ Yes ☐ No Sore throat or voice change
☐ Yes ☐ No Swollen glands in neck
☐ Yes ☐ No Ringing in the ears
☐ Yes ☐ No Earaches or drainage
☐ Yes ☐ No Sinus problems
☐ Yes ☐ No Nose bleeds
☐ Yes ☐ No Hearing loss

Gastrointestinal

☐ Yes ☐ No Stomach pain
☐ Yes ☐ No Blood in stool
☐ Yes ☐ No Nausea or vomiting
☐ Yes ☐ No Frequent diarrhea
☐ Yes ☐ No Constipation
☐ Yes ☐ No Painful bowel movements
☐ Yes ☐ No Loss of appetite

Have you ever been diagnosed with:

☐ Yes ☐ No Hepatitis A, B or C
☐ Yes ☐ No HIV/AIDS
☐ Yes ☐ No MRSA
☐ Yes ☐ No Tuberculosis/TB
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Cancer

Genitourinary

☐ Yes ☐ No Frequent urination
☐ Yes ☐ No Incontinence or dribbling of urine
☐ Yes ☐ No Blood in urine
☐ Yes ☐ No Change in force or strain when urinating
☐ Yes ☐ No Kidney stones
☐ Yes ☐ No History of renal failure
☐ Yes ☐ No Sexual difficulties

Respiratory (Lungs)

☐ Yes ☐ No Spitting up blood
☐ Yes ☐ No Shortness of breath
☐ Yes ☐ No Asthma or wheezing
☐ Yes ☐ No Frequent coughing

Musculoskeletal

☐ Yes ☐ No Joint Pain, stiffness or swelling
☐ Yes ☐ No Muscle pain or cramps
☐ Yes ☐ No Muscle weakness
☐ Yes ☐ No Neck pain
☐ Yes ☐ No Back pain
☐ Yes ☐ No Difficulty walking

Endocrine

☐ Yes ☐ No Glandular or hormone problem
☐ Yes ☐ No Heat or cold intolerance
☐ Yes ☐ No Excessive dry skin
☐ Yes ☐ No Excessive thirst or urination

Psychiatric

☐ Yes ☐ No Memory loss or confusion
☐ Yes ☐ No Anxiety/nervousness
☐ Yes ☐ No Mood changes
☐ Yes ☐ No Depression
☐ Yes ☐ No Bipolar Disorder
☐ Yes ☐ No Sleep problems

If yes, are you insulin dependent? ☐ Yes ☐ No

Cardiovascular (Heart)

☐ Yes ☐ No Chest pains
☐ Yes ☐ No Sudden heartbeat changes
☐ Yes ☐ No Swelling feet, ankles or hands
☐ Yes ☐ No Heart trouble
☐ Yes ☐ No High blood pressure
☐ Yes ☐ No History of Endocarditis

Neurological

☐ Yes ☐ No Frequent or recurring headaches
☐ Yes ☐ No Light-headed or dizziness
☐ Yes ☐ No Convulsions or seizures
☐ Yes ☐ No Numbness or tingling sensations
☐ Yes ☐ No Tremors
☐ Yes ☐ No Stroke
☐ Yes ☐ No Previous head injury/ Traumatic Brain Injury
☐ Yes ☐ No History of seizures

Skin and Breasts

☐ Yes ☐ No Rash or itching
☐ Yes ☐ No Change in hair or nails
☐ Yes ☐ No Non-healing sores/Abscesses
☐ Yes ☐ No Change in appearance of moles
☐ Yes ☐ No Breast pain
☐ Yes ☐ No Breast lump
☐ Yes ☐ No Breast discharge

Female only

☐ Yes ☐ No Irregular periods
☐ Yes ☐ No Painful periods
☐ Yes ☐ No Vaginal discharge
☐ Yes ☐ No Hysterectomy
☐ Yes ☐ No Birth control

Female Only: ☐ NA

Date of last Pap smear: _____ Date of last mammogram: _____ Date of last menstrual period: _____

Health Assessment Questionnaire

Are you planning a pregnancy? ☐ Yes ☐ No Method of birth control: _____ Are you nursing a child? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If pregnant, are you getting prenatal care? ☐ Yes ☐ No If yes, Provider Name: _____

Provider Address: _____ Phone Number: _____ Fax: _____

Patient Name: _____ DOB: _____ Date: _____

Operations:

Please list any surgery and approximate year:

Year Surgery

_____ _____

_____ _____

_____ _____

Hospitalizations:

Please list hospitalization that were not related to a surgery/operation:

Year Reason Hospital

_____ _____

_____ _____

_____ _____

DENTAL INFORMATION

How often do you see a dentist? ☐ Every 6 months ☐ Once a year ☐ Not regularly ☐ Never

Name of Dentist: _____ Phone: _____

Dentist Address: _____ Fax: _____

Date of last dental visit: _____ Reason for visit: _____

Do you have any concerns about your teeth or oral health? ☐ Yes ☐ No If yes, please list: _____

VISION INFORMATION

Have you ever had your eyes/vision tested? ☐ Yes ☐ No

Do you have trouble with your eyesight? ☐ Yes ☐ No If yes, please explain: _____

Name of Vision Provider: _____ Phone: _____

Vision Provider Address: _____ Fax: _____

Date of last vision exam: _____ Reason: _____

MEDICATION INFORMATION

Are you prescribed medications by a medical provider? ☐ Yes ☐ No

Please list all medications you are taking regularly. Including over the counter, herbal or natural remedies.

_____

_____

_____

Do you use any prescription medication that is not prescribed to you? ☐ Yes ☐ No Please list: _____

_____

Do you take less or more of a prescribed medication? ☐ Yes ☐ No Please explain: _____

_____

Substance	Route: oral, nasal, smoking, IV	Age of 1st Use	Date of last use:	Amount Used:	How often do you use? Daily, weekly, etc.	Has your use of this substance - increased, decreased or stopped?	Symptoms within the past 12 months - Withdrawal, loss of control, tolerance? Yes or No
Alcohol							
Benzodiazepines							
Cannabis/Marijuana							
Crack/Cocaine							
Hallucinogens							
Heroin							
Inhalants							
Methadone							
Methamphetamine							
Nicotine/Tobacco							
Suboxone/Subutex							
Prescription Opiates							
Other Sedative/ Tranquilizers							
Other: _____							

Health Assessment Questionnaire

Where have you been living the past 30 days: _____

Do you have any concerns you would like to address with a nurse or medical provider?

_____

_____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Reviewed by:

Nurse or Provider Signature: _____ Date: _____

Nurse or Provider Recommendations:

_____

_____

_____