

# Health Assessment Questionnaire

R 4/1/20, 10/24/19, 5/9/19, 3/07/19, 2/26/19, 12/01/17

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:**

<b>Conditional (General)</b>		<b>Genitourinary</b>		<b>Cardiovascular (Heart)</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent weight change	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest pains
<input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence or dribbling of urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sudden heartbeat changes
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling feet, ankles or hands
<b>Eyes and Vision</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in force or strain when urinating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart trouble
<input type="checkbox"/> Yes <input type="checkbox"/> No	Wear glasses/contact lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney stones	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure
<input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred or double vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	History of renal failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	History of Endocarditis
<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexual difficulties	<b>Neurological</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye injury or disease	<b>Respiratory (Lungs)</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent or recurring headaches
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Ears, Nose, Throat</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spitting up blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Light-headed or dizziness
<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions or seizures
<input type="checkbox"/> Yes <input type="checkbox"/> No	Bad breath or bad taste	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma or wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness or tingling sensations
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sore throat or voice change	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent coughing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tremors
<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen glands in neck	<b>Musculoskeletal</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke
<input type="checkbox"/> Yes <input type="checkbox"/> No	Ringing in the ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Pain, stiffness or swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Previous head injury/Traumatic Brain Injury
<input type="checkbox"/> Yes <input type="checkbox"/> No	Earaches or drainage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle pain or cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	History of seizures
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle weakness	<b>Skin and Breasts</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Nose bleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash or itching
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in hair or nails
<b>Gastrointestinal</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty walking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Non-healing sores/Abscesses
<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach pain	<b>Endocrine</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in appearance of moles
<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in stool	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glandular or hormone problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast pain
<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea or vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heat or cold intolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast lump
<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive dry skin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast discharge
<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive thirst or urination	<b>Female only</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful bowel movements	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Psychiatric</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular periods
<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No	Memory loss or confusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful periods
<b>Have you ever been diagnosed with:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety/nervousness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal discharge
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A, B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mood changes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hysterectomy
<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Birth control
<input type="checkbox"/> Yes <input type="checkbox"/> No	MRSA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bipolar Disorder		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis/TB	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep problems		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	If yes, are you insulin dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer				

**Female Only:** ☐ NA

Date of last Pap smear: \_\_\_\_\_ Date of last mammogram: \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_

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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 eye sight? ☐ 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

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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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_