

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:

Conditional (General)		Genitourinary		Cardiovascular (Heart)	
<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	Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Incontinence or dribbling of urine
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood in urine
Eyes and Vision		Respiratory (Lungs)		Neurological	
Wear glasses/contact lenses		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent or recurring headaches	
<input type="checkbox"/> Yes		Blurred or double vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Light-headed or dizziness
<input type="checkbox"/> Yes		Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Convulsions or seizures
<input type="checkbox"/> Yes		Eye injury or disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Numbness or tingling sensations
Ears, Nose, Throat		Musculoskeletal		Stroke	
<input type="checkbox"/> Yes		Bleeding gums	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Previous head injury/Traumatic Brain Injury
<input type="checkbox"/> Yes		Bad breath or bad taste	<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of seizures
<input type="checkbox"/> Yes		Sore throat or voice change	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin and Breasts
<input type="checkbox"/> Yes		Swollen glands in neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rash or itching
<input type="checkbox"/> Yes		Ringing in the ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Change in hair or nails
<input type="checkbox"/> Yes		Earaches or drainage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Non-healing sores/Abscesses
<input type="checkbox"/> Yes		Sinus problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Change in appearance of moles
<input type="checkbox"/> Yes		Nose bleeds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Breast pain
<input type="checkbox"/> Yes		Hearing loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Breast lump
Gastrointestinal		Endocrine		Breast discharge	
<input type="checkbox"/> Yes		Stomach pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Female only
<input type="checkbox"/> Yes		Blood in stool	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Irregular periods
<input type="checkbox"/> Yes		Nausea or vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Painful periods
<input type="checkbox"/> Yes		Frequent diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vaginal discharge
<input type="checkbox"/> Yes		Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Yes		Painful bowel movements	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Yes		Loss of appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever been diagnosed with:		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<input type="checkbox"/> Yes		Hepatitis A, B or C	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mood changes
<input type="checkbox"/> Yes		HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression
<input type="checkbox"/> Yes		MRSA	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bipolar Disorder
<input type="checkbox"/> Yes		Tuberculosis/TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep problems
<input type="checkbox"/> Yes		Diabetes	If yes, are you insulin dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Yes		Cancer			

Female Only: NA

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

Health Assessment Questionnaire

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

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

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

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:

