



Place Label Here

Partners

Health Questionnaire

Please arrive 30 minutes prior to your appointment

Last Name:	First Name:	DOB:	<input type="checkbox"/> F <input type="checkbox"/> _____ <input type="checkbox"/> M
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			Occupation:
Previous or Referring Doctor:		Date of last physical exam:	

Medications: Please bring all prescription medications you are currently taking

Name	Dose and Directions	Reason

Allergies and Reactions: _____

Do you currently have, or have ever had, any of the following illnesses or conditions?

- | | | |
|--|--|---|
| <input type="checkbox"/> Abnormal Pap | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alcohol/Drug Problem | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other Injuries |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Peripheral Artery Disease |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Positive TB Test |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychiatric-Depression |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Psychiatric-Other |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hernia | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chronic Lung Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Colon/Bowel Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Infection of the uterus | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes Type I or II | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Ulcer |

Surgical and Hospitalization History (include dates)

Family History <i>(Use back of page if needed)</i>		Age	Medical conditions Indicate Healthy -or- diabetes, high blood pressure, cholesterol, heart disease, stroke, cancer (type)	
Mother	<input type="checkbox"/> Living <input type="checkbox"/> Deceased			
Father	<input type="checkbox"/> Living <input type="checkbox"/> Deceased			
Sibling	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Living <input type="checkbox"/> Deceased			
Sibling	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Living <input type="checkbox"/> Deceased			
Sibling	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Living <input type="checkbox"/> Deceased			
Sibling	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Living <input type="checkbox"/> Deceased			
Grandmother Mother's Side	<input type="checkbox"/> Living <input type="checkbox"/> Deceased			
Grandfather Mother's Side	<input type="checkbox"/> Living <input type="checkbox"/> Deceased			
Grandmother Father's Side	<input type="checkbox"/> Living <input type="checkbox"/> Deceased			
Grandfather Father's Side	<input type="checkbox"/> Living <input type="checkbox"/> Deceased			
Children	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Living <input type="checkbox"/> Deceased			
Children	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Living <input type="checkbox"/> Deceased			
Extended Family Members		<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart attacks	<input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes

Patient History	
Smoking	Cigarette Use: <input type="checkbox"/> Never <input type="checkbox"/> Former Smoker Date quit or age: <input type="checkbox"/> Current Smoker
	Other tobacco use: <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars <input type="checkbox"/> Chewing Tobacco
	Other: <input type="checkbox"/> e-Cigarettes <input type="checkbox"/> Marijuana
Alcohol	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> 0-1 times/month <input type="checkbox"/> 2-4 times/month <input type="checkbox"/> Every week <input type="checkbox"/> No
	Each week, how many: _____ Servings of beer? _____ Glasses of wine? _____ Shots/mixed drinks? _____ When did you last have more than 4 drinks in one day? _____
	Do you feel you should cut down on your drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do people annoy you by nagging about your drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever felt guilty about drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever had a morning drink to steady your nerves? <input type="checkbox"/> Yes <input type="checkbox"/> No
Drugs	Have you used recreational or street drugs within the last two years? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever used recreational drugs with a needle? <input type="checkbox"/> Yes <input type="checkbox"/> No
Sexual Health	<input type="checkbox"/> Sexually active <input type="checkbox"/> Not currently sexually active <input type="checkbox"/> Never sexually active
	Sexual Partners: <input type="checkbox"/> Men <input type="checkbox"/> Women # of Partners in last year:
	History of Sexually Transmitted infections? If yes, type/dates:
	Current contraception method: Previous methods:
	Women: # of children: _____ # of pregnancies: _____ # of miscarriages: _____ # of abortions: _____ Date of last menstrual period:

Personal Safety	Do you wear a seatbelt?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you fallen in the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, how many times? _____ Any injuries? _____	
	Do you feel unsteady when standing or walking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you worry about falling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does your house have a working smoke detector?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does a partner, or anyone at home, hurt, hit, or threaten you, or take advantage of you financially?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient Health	Over the last two weeks, how often have you been bothered by any of the following problems?	
	Little interest or pleasure in doing things	<input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half of the Days <input type="checkbox"/> Nearly Every Day
	Feeling down, depressed, or hopeless	<input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half of the Days <input type="checkbox"/> Nearly Every Day
Exercise	<input type="checkbox"/> Sedentary (No exercise)	
	<input type="checkbox"/> Mild Exercise (i.e., climb stairs, walk three blocks, golf)	
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation 1-3x week for 30 minutes)	
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation > 3x/week for 30 minutes)	

Immunizations	Date	Immunization	Date
<input type="checkbox"/> Flu Vaccine		<input type="checkbox"/> TD (Tetanus Shot)	
<input type="checkbox"/> TDAP (Whooping Cough/Tetanus)		<input type="checkbox"/> Zostavax (Shingles) <input type="checkbox"/> Shingrix (Shingles)	
<input type="checkbox"/> Pneumococcal PCV13		<input type="checkbox"/> HPV	
<input type="checkbox"/> Pneumococcal PPV23		<input type="checkbox"/> Meningococcal ACWY	
<input type="checkbox"/> Hepatitis A		<input type="checkbox"/> Meningococcal B	
<input type="checkbox"/> Hepatitis B		<input type="checkbox"/> Other:	

Please list the names of the physicians and specialists you have seen:

Previous Primary Care		Gynecologist	
Gastroenterologist (GI)		Urologist	
Cardiologist		Eye doctor	
Other		Other	

Preventative Screenings: To avoid duplication and to provide you with the best care possible, we would like the information on the following items and to obtain a copy of your most recent reports. **Either bring a us a copy or let us know from where we can request a copy.** (Not all ages and genders will need to provide the information listed below.)

Item	Date last performed	Result (if applicable)	Comments
Aortic Aneurysm Screen			
Bone Density Test			
Cholesterol Test			
Colonoscopy			
Dental Exam			
Eye Exam			
Hepatitis C Test			
HIV Test			
HPV Test			
Mammogram			
Pap Smear			
Prostate Exam			
Stool Test for Blood			

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