

Alder Brook Family Health

PATIENT QUESTIONNAIRE FOR PHYSICAL EXAMINATIONS:

Name: _____ Date of Birth: _____ Today's date: _____

1. Your typical Day and Health Habits

Circle what best describes your situation: Single, Married, Divorced, Widowed, Engaged, Partnership, Civil Union, Committed relationship

Relationships and ages of those living with you _____

Time you get up: _____ Time you go to bed: _____ Work hours: _____

Occupation: _____

Occupation of partner/spouse _____ Name of partner/spouse _____

Please describe your typical meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How many 8 oz servings of calcium rich foods (milk, cheese, yogurt) do you consume per day? _____

What do you do for exercise? _____

How many days per week? _____ How many hours per week? _____

What are your hobbies? _____

What else do you do for fun? _____

What religious social or community activities are you involved in? _____

1. Do you have a living will/ medical power of attorney? ----- Y N
2. Do you always wear your seatbelt? ----- Y N
3. Do you always wear a helmet when bicycling or motorcycling? ----- Y N
4. How many cups of caffeinated coffee, tea or soda do you drink per day? _____
5. Do you smoke? ----- Y N
 - How many cigarettes per day? _____
 - Did you smoke in the past? ----- Y N
 - When did you quit? _____
6. Do you chew tobacco? ----- Y N
7. Do you drink alcohol? ----- Y N
 - If no skip to question 12
8. What is your average number of drinks per day? _____
 - (1 drink = 1.5 oz liquor, 12 oz. beer, or 5 oz. wine)
9. Have you been concerned enough about your drinking to feel you should cut down? -----Y N
10. Have you been annoyed by people's comments about your drinking? ----- Y N
11. Have you ever felt guilty about your drinking? ----- Y N

- 12. Have you had a drink first thing in the morning to steady your nerves or get rid of a hangover? ----- Y N
- 13. Have you had a drink in the last 24 hours? ----- Y N
- 14. Have you ever had an alcohol problem? -----Y N
- 15. In the past year have you used opiates, heroin, hallucinogens (such as LSD), cocaine or amphetamines (such as speed or crystal meth)? ----- Y N
 Have you ever used these drugs in the past? -----Y N
 Have you ever injected drugs? -----Y N
- 16. In the past year have you used marijuana? -----Y N

MEDICAL HISTORY: Please fill out if you have NOT previously had a physical exam here. If you are not a new patient, please only list new conditions or surgeries.

Please list any known medical conditions (such as diabetes, high blood pressure, depression, etc...)

Please list any past surgeries:

Surgery	Doctor/hospital	Date

Please list any other hospitalizations:

Reason for hospitalization	Doctor/hospital	Date

EVERYONE CONTINUE HERE PLEASE:

Immunization Questions

- 1. Date of last Tetanus Shot _____
- 2. Have you had 2 measles shots? ----- Y N
- 3. Have you had a pneumonia vaccine? ----- Y N
- 4. Have you had or been vaccinated against chickenpox? ----- Y N
- 5. Are you exposed to blood or blood products?----- Y N
- 6. Have you had your spleen removed?----- Y N
- 7. Have you had hepatitis B vaccine? Y N Hepatitis A vaccine? Y N Typhoid vaccine Y N

MEDICATIONS: including prescription, over-the-counter, herbal. Add additional sheet if necessary:

<i>Medication</i>	<i>Dose</i>	<i>Reason prescribed</i>	<i>Doctor prescribing</i>

Drug allergies: (include latex and adhesive tape allergies, if present)

<i>Medication</i>	<i>Type of reaction</i>

Family History

Do you have a first-degree relative (parent, brother, sister, child) or aunts, uncles, grandparents with:

	Y	N	relationship	age
a. heart attack, angina or heart surgery before age 60?				
b. breast cancer?-----				
c. colon cancer, rectal cancer or polyps?-----				
d. prostate cancer?-----				
e. ovarian cancer?-----				
f. diabetes or "sugar"?-----				
g. melanoma?-----				
h. glaucoma?-----				
i. osteoporosis?-----				
j. high cholesterol?-----				
k. aortic aneurysm?-----				
Are there any other diseases that run in your family? Specify please_____				

REVIEW OF SYSTEMS Please circle any symptoms you have had.

Eyes, ears, nose, throat

Have you had in the past year:

- 1. failing vision not correctable by glasses?-----Y N
- 2. trouble with your hearing?-----Y N
- 3. persistent pain or difficulty in swallowing?----Y N
- 4. persistent sore throats?-----Y N
- 5. treatment for an eye problem-----Y N
- 6. frequent nosebleeds?-----Y N
- 7. When was your last eye exam?_____
- 8. When was your last dental exam?_____

Cardiovascular/Respiratory

Have you had in the past six months:

- 1. chest pain, heaviness or pressure?-----Y N
- 2. skipped or irregular heartbeats?-----Y N
- 3. breathlessness or cough that awakens
you at night?-----Y N
- 4. ankle swelling?-----Y N
- 5. calf pain with walking?-----Y N
- 6. shortness of breath with exertion?-----Y N
- 7. coughing up blood?-----Y N
- 8. cough lasting longer than a usual cold? Y N

Skin

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Have you had recently:

- 1. a changing skin mole?-----Y N
- 2. skin cancer?----- Y N
- 3. an unusual skin rash?-----Y N

Gastroenterology

Have you had in the past year?

- 1. vomiting of blood?-----Y N
- 2. frequent heartburn----- Y N
- 3. bloody bowel movements?-----Y N
- 4. significant change in bowel movements?-----Y N
- 5. frequent diarrhea or constipation?-----Y N

Musculoskeletal

- 1. Have you had back pain which caused you to miss work? -----Y N
- 2. Have you had pain and swelling in your joints making it difficult to function ?-----Y N

For Men Only

- 1. Have you had any urinary dribbling, frequent urination, difficulty starting or stopping urination?----Y N
- 2. Have you been up at night urinating?-----Y N
- 2. Do you want to discuss any sexual problems?-----Y N
- 3. Do you have sex with ? **Circle: Men Women Both**
- 4. Have you had a sexually transmitted disease? Gonorrhea, Chlamydia, Genital warts, Herpes, HIV, syphilis Y N

For Women Only

- 1. Date of last menstrual period: _____
- 2. Do you think you may be pregnant? ----- Y N
- 3. What are you using for birth control? **Circle: birth control pills, IUD, Condoms, Nuvaring, Patch, Depo Shot, Tubes tied, partner had a vasectomy, none, rhythm method, withdrawal**
- 4. Have you ever been on hormone replacement?----- Y N
- 5. Have you had vaginal bleeding after menopause? -----Y N
- 6. Have you had bleeding between periods?-----Y N
- 7. Have you had an abnormal PAP smear?-----Y N
- 8. Do you want to discuss any sexual problems or do you have any questions about sexual issues? Y N
- 9. Have you had a sexually transmitted disease? (Gonorrhea, Syphilis, Herpes, Chlamydia, Genital warts, HIV) --- Y N
- 10. Do you have sex with ? **Circle: Men, Women, Both, Neither**
- 11. Have you had a new sexual partner since your last PAP smear?-----Y N
- 12. Date of last PAP smear? _____
- 13. Date of last mammogram? _____
- 14. Have you ever had an abnormal mammogram?-----Y N
- 15. Would you like information on birth control?-----Y N
- 16. How frequent are your periods _____ How long do they last? ____ Is bleeding heavy? Light?
- 17. Are your periods regular?-----Y N
- 18. How many pregnancies have you had? _____ Miscarriages? _____ Abortions? _____
- 19. Have you had a bone density test? -----Y N
- 20. Have you had increased frequency of urination?-----Y N
- 21. Have you had trouble holding your urine or getting to the bathroom on time?-----Y N
- 22. Have you had blood in your urine?-----Y N
- 23. If you are a Medicare patient, have you had more than 3 sexual partners in your lifetime? -----Y N

Neurological

- 1. Are you regularly bothered by headaches that leave you unable to function or are worsening? -----Y N
- 2. Do you have frequent dizziness?-----Y N
- 3. Have you had frequent falls?-----Y N
- 4. Have you had numbness of arms or legs? Y N
- 5. Have you had any trouble speaking or moving your arms or legs recently? -----Y N

Endocrine

- 1. Have you had a recent weight loss of 10 pounds or more without change of diet or activity?-----Y N
- 2. Have you had severe fatigue in the past month causing you to miss work?-----Y N
- 3. Have you had significant weight gain? Y N
- 4. What was your estimated high school graduation weight? _____

If so, how many times on average? _____

Hematology

- 1. Have you ever had a blood transfusion? Y N

Psychological

1. Are you have any problems with any of the following areas of your life that you'd like to discuss?
- 1. Relationships 2. Children
 - 3. Extended family 4. Work
2. Are you recently divorced , separated, or widowed? -----Y N
3. Have you had a death in the family in the past year? -----Y N
4. Have you been a victim of physical or sexual abuse? -----Y N
5. Do you feel safe at home? -----Y N
6. Have you had panic attacks? -----Y N
7. Have you had nervous breakdown or been hospitalized for your nerves? -----Y N
8. Have you attempted suicide? -----Y N
9. Have you had a family member commit suicide? -----Y N
10. Do you want counseling for any problems? -----Y N

A note to patients: Depression is a highly treatable, very common condition in any primary care practice. It's important to screen for this disease. Please take the time to fill out this clinically proven depression scale.

Over the past 2 weeks, how often have you :	None or little	Some	Most of the	All of
(Check box that applies)	of the time	of the time	time	the time
1. been feeling low in energy, slowed down?				
2. been blaming yourself for things?				
3. had poor appetite?				
4. had difficulty falling asleep staying asleep?				
5. been feeling hopeless about the future?				
6. been feeling blue?				
7. been feeling no interest in things?				
8. had feelings of worthlessness?				
9. have thought about, or wanted to commit suicide?				
10. had difficulty concentrating or making decisions?				

Do you have any other problems to discuss with your provider? _____
