Health Care Consumer Questionnaire

Patient Name _____ **DOB** ____/____/_____ **Date** ____/____/_____

*In order to best serve your medical needs, we ask that you complete the following questionnaire as completely as possible. The **Health Care Consumer (HCC) - Health Care Provider (HCP)** relationship is a privileged relationship built on trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false information may seriously and adversely affect your health.*

Patient Name **Gender** ❑M ❑F

Date of Birth (*MM/DD/YYYY* **Social Security Number**

Reason for Visit

If the person completing this form is not the patient, please write your name, your relationship to the patient, and why the patient is unable to complete the form.

Name	**Relationship to Patient**
Reason	

Health Care Consumer's Address		**Phone**
	Home	
	Work	
	Cell	

Emergency Contact (Address and Phone)

	Home	
	Work	
	Cell	

Insurance Information		**Phone**
Policy #		

Additional, or Secondary Insurance Company

Policy #		

Have you designated a Durable Power of Attorney for Health Care? ❑**Yes** ❑**No**

If yes, please provide a copy for your health care provider.

Do you have any religious or cultural beliefs that may impact your health care? If yes, describe ❑**Yes** ❑**No**

I best learn new information by: ❑Verbal Instruction ❑Written Instruction ❑Handouts ❑Pictures

Level education completed ❑<6th grade ❑6th – 9th grade ❑12th grade ❑1-4 years college ❑>4 years college

I understand English well ❑**Yes** ❑**No** **If NO, please specify the language you prefer**

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Names and Phone Numbers for Health Care Providers (HCPs) from whom you are currently receiving care (or have seen within the past 12 months), or from whom you have received prescriptions.

	Contact #	
	Contact #	
	Contact #	
	Contact #	
	Contact #	
	Contact #	

Please list all of the medications you are taking. Include over the counter medications, herbs & vitamins.

Medication Name	*Dose*	*Last taken*	*Medication Name*	*Dose*	*Last taken*

Please list and describe allergic reactions you have had to food, medications or insect stings.

Check if you are you allergic to ❑Shellfish _____ ❑IV Contrast Dye _____ ❑Penicillins _____

Please list other Food, Medication or Insect Allergies	Describe your reaction

Please list your occupations. Include the length of time you performed in that role, and describe your work responsibilities in that occupation. (Include military experience.)

Occupation	Start Date	Stop Date	Responsibilities

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Have you ever been exposed to known cancer causing agents or inhalation hazards? ❑Yes ❑No
Examples: asbestos, paints, aniline dyes, chemicals, silica, etc.

Agent	Exposure time	Problems related to exposure

Please describe your hobbies.

Have you traveled, in the past 1 year? ❑Yes ❑No

Travel destinations OUTSIDE the United States	Dates spent at this destination

Travel destinations INSIDE the United States	Dates spent at this destination

Exercise History

Do you exercise? ❑Yes ❑No If yes, describe how long and how often you exercise on average each week

History of Falls

In the past 12 months, have you fallen?	**❑Yes ❑No**
If yes, how many times?	
If yes, have you ever broken bones, or sustained an injury, as a result of falling?	**❑Yes ❑No**

Vaccination History Have you ever had any of the following vaccinations?

Vaccine		Date of last vaccination
Influenza	❑Yes ❑No	
Pneumonia	❑Yes ❑No	
Tetanus	❑Yes ❑No	
BCG	❑Yes ❑No	
Varicella	❑Yes ❑No	
HPV (Gardasil)	❑Yes ❑No	

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Tobacco Use History		If yes, describe
Have you ever smoked?	❑Yes ❑No	# packs per day X # years
Have you chewed tobacco?	❑Yes ❑No	
Have you smoked pipes or cigars?	❑Yes ❑No	#cigars or pipe bowls per ❑Day ❑Week
Have you quit?	❑Yes ❑No	When
Have you consider quitting?	❑Yes ❑No	Have you set a date? ❑Yes ❑No
Have you tried quitting?	❑Yes ❑No	What was the longest time you quit?

Alcohol Use History		If yes, describe
Do you now, or did you once, regularly drink alcohol?	❑Yes ❑No	# drinks per ❑Day ❑Week
1 "drink" is equal to 12 oz. can of beer, 1.5 oz. liquor (80 proof) or 5 oz wine		
Have you ever "blacked out" due to alcohol intake?	❑Yes ❑No	
Have you had a drink to prevent the "shakes", "sweats", or developing other problems?	❑Yes ❑No	
Have you ever been arrested or ticketed for DUI (Driving Under the Influence)?	❑Yes ❑No	
Have you been involved in any motor vehicle accidents in the past 12 months?	❑Yes ❑No	

Recreational Drug Use History	
Do you now use, or have you ever used, drugs for recreational purposes?	❑Yes ❑No
If yes, check all that apply ❑Amphetamines ❑Cocaine ❑Marijuana ❑Heroin ❑Inhalants ❑LSD	
Describe the method of delivery you chose ❑Ingestion ❑Injection ❑Inhalation	
Have you quit?	❑Yes ❑No
Have you ever taken drugs to prevent the "shakes", "sweats", or developing other problems?	❑Yes ❑No
Have you ever had a problem with addiction to prescription pain medication or benzodiazepines (like Valium, Xanax, etc.)?	❑Yes ❑No

Hepatitis, HIV and STD risk factors	
Are you sexually active?	❑Yes ❑No
If yes, do you practice birth control?	❑Yes ❑No
What birth control method do you use? Check all that apply ❑Condoms ❑Diaphragm ❑IUD (Intrauterine Device) ❑Birth Control Pills, Patches, Implants	
How many sexual partners have you had in the past 1 year? *Specify here*	
Have you ever had sex with a person who is the same gender as yourself, bisexual, or anyone who performs sexual favors in exchange for money or drugs?	❑Yes ❑No
Have you EVER been diagnosed with a sexually transmitted disease "STD" (like syphilis, gonorrhea, chlamydia or HIV), or were you exposed to a STD during childbirth?	❑Yes ❑No
Do you have any tattoos or body piercings?	❑Yes ❑No
Have you received any transfusions of blood or blood products?	❑Yes ❑No

Seatbelt Use
Describe your seatbelt use when you are driving, or a passenger in a vehicle ❑All the time ❑Most of the time ❑About half the time ❑Rarely ❑Never

Firearm Safety	
Do you keep firearms in your place of residence?	❑Yes ❑No
If yes, are they kept in locked compartments, or do they have safety locks?	❑Yes ❑No

Can you perform your own hygiene, dressing, cooking and shopping needs independently?	❑Yes ❑No

Have you ever been in a relationship where you were threatened, hurt or afraid?	❑Yes ❑No

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Prior Diagnostic Tests Have you ever had any of the following exams?

Test	Response	Approximate date and Reason
PAP Smear	❑Yes ❑No	
Prostate Biopsy	❑Yes ❑No	
Mammogram	❑Yes ❑No	
Colonoscopy	❑Yes ❑No	
EGD (Esophageal endoscopy)	❑Yes ❑No	
EKG	❑Yes ❑No	
Cardiac stress test	❑Yes ❑No	
ECHO	❑Yes ❑No	
Chest x-ray	❑Yes ❑No	
CT "CAT" scan of chest	❑Yes ❑No	
Pulmonary function test	❑Yes ❑No	
EEG	❑Yes ❑No	
Bone density test	❑Yes ❑No	

Female Patients Only

	Response	Descriptions
Have you ever been pregnant	❑Yes ❑No	
# of pregnancies		
# Live Births		
# Miscarriages, Abortions		
Your age at onset of menstruation		
Your age at onset of menopause	❑NA	
Have you ever taken birth control pills, or used patches or implants? If yes, how long	❑Yes ❑No	
Have you ever used hormone replacement therapy? If yes, how long	❑Yes ❑No	
Did you ever have an IUD (Intrauterine Device) implanted?	❑Yes ❑No	
If you had an IUD, was it removed? If yes, when	❑Yes ❑No	

Surgical History

Surgery or Procedure	Date of Procedure	Name of Provider Performing Procedure

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Past Medical History Please check all that apply.

Adrenal Dysfunction	❑Yes ❑No	**Irregular Heart Rhythm**	❑Yes ❑No
Alzheimer	❑Yes ❑No	**Kyphosis**	❑Yes ❑No
Amyotrophic Lateral Sclerosis	❑Yes ❑No	**Liver Dysfunction**	❑Yes ❑No
Anorexia or Bulimia	❑Yes ❑No	**Kidney Failure, or Dysfunction**	❑Yes ❑No
Anxiety Disorder	❑Yes ❑No	**Malignancy** If yes, describe below	❑Yes ❑No
Arteriovenous Malformations (AVMs)	❑Yes ❑No		
Arthritis	❑Yes ❑No		
Asthma	❑Yes ❑No	**Mania**	❑Yes ❑No
Autoimmune Disease	❑Yes ❑No	**Muscular Dystrophy**	❑Yes ❑No
Bipolar Disorder	❑Yes ❑No	**Myocardial Infarction (Heart Attack)**	❑Yes ❑No
Bleeding Disorder	❑Yes ❑No	**Narcolepsy**	❑Yes ❑No
Cataracts	❑Yes ❑No	**Obstructive Sleep Apnea**	❑Yes ❑No
Cerebrovascular Accident (Stroke)	❑Yes ❑No	**Organ Transplant** If yes, describe	❑Yes ❑No
Chemotherapy If yes, state when	❑Yes ❑No		
		Osteoporosis	❑Yes ❑No
Claudication	❑Yes ❑No	**Pancreatitis**	❑Yes ❑No
Clotting Disorder	❑Yes ❑No	**Periodic Limb Movement Disorder**	❑Yes ❑No
Congenital Heart Defects	❑Yes ❑No	**Peripheral Artery Disease**	❑Yes ❑No
Coronary Artery Disease	❑Yes ❑No	**Personality Disorder**	❑Yes ❑No
COPD	❑Yes ❑No	**Pituitary Dysfunction**	❑Yes ❑No
Cystic Fibrosis	❑Yes ❑No	**Polycystic Ovarian Syndrome**	❑Yes ❑No
Depression	❑Yes ❑No	**Pulmonary Artery Hypertension**	❑Yes ❑No
Diabetes	❑Yes ❑No	**Pulmonary fibrosis**	❑Yes ❑No
Dialysis	❑Yes ❑No	**Radiation Therapy** If yes, explain	❑Yes ❑No
Eclampsia or Pre-eclampsia	❑Yes ❑No		
Endocarditis	❑Yes ❑No	**Recurrent Infections**	❑Yes ❑No
Endometriosis	❑Yes ❑No	**Restless Leg Syndrome**	❑Yes ❑No
End Stage Renal Disease	❑Yes ❑No	**Sarcoidosis**	❑Yes ❑No
Erectile Dysfunction	❑Yes ❑No	**Schizophrenia**	❑Yes ❑No
Esophageal Dysfunction	❑Yes ❑No	**Scleroderma**	❑Yes ❑No
Fibromyalgia	❑Yes ❑No	**Scoliosis**	❑Yes ❑No
Gallstones	❑Yes ❑No	**Seizure Disorder**	❑Yes ❑No
Gastritis or Gastric Ulcers	❑Yes ❑No	**Sickle Cell**	❑Yes ❑No
GERD (reflux problems)	❑Yes ❑No	**Sjogren**	❑Yes ❑No
Glaucoma	❑Yes ❑No	**Skin Disorders (Psoriasis, Acne)**	❑Yes ❑No
Heart or Valve Defects	❑Yes ❑No	**Thalassemia**	❑Yes ❑No
Hemochromatosis	❑Yes ❑No	**Thrombocytopenia**	❑Yes ❑No
Hemorrhoids	❑Yes ❑No	**Thrombophilia**	❑Yes ❑No
Hepatitis	❑Yes ❑No	**Transfusions**	❑Yes ❑No
HIV or AIDS	❑Yes ❑No	**Tuberculosis**	❑Yes ❑No
Hypertension	❑Yes ❑No	If yes, have you been treated?	❑Yes ❑No
Hyperthyroidism	❑Yes ❑No	**Urinary retention or urgency**	❑Yes ❑No
Hypotension	❑Yes ❑No	**Vasculitis**	❑Yes ❑No
Hypothyroidism	❑Yes ❑No	**Visual defects**	❑Yes ❑No
Inflammatory Bowel Disease	❑Yes ❑No	**Vocal cord dysfunction/paralysis**	❑Yes ❑No

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Review of Systems In the last 6 months, have you experienced any of the following symptoms? Respond to each.

Constitutional			
Weight Loss or Gain	❑Yes ❑No	Blood in your urine	❑Yes ❑No
Appetite changes (increased or decreased)	❑Yes ❑No	Menstrual changes	❑Yes ❑No
Fatigue, profound and impairs daily function	❑Yes ❑No	Urinating that is painful or difficult	❑Yes ❑No
Fever	❑Yes ❑No	Erection problems	❑Yes ❑No
Shakes/sweats from lack of alcohol or drug	❑Yes ❑No	Vaginal discharge or bleeding	❑Yes ❑No
Eyes		**Musculoskeletal**	
Eye pain or drainage	❑Yes ❑No	Broken bones	❑Yes ❑No
Visual changes	❑Yes ❑No	Joint pain or swelling	❑Yes ❑No
Dry, irritated eyes	❑Yes ❑No	Muscle aches	❑Yes ❑No
ENT/Mouth		Muscle weakness	❑Yes ❑No
Ear pain or drainage	❑Yes ❑No	Back pain	❑Yes ❑No
Frequent sinus infections	❑Yes ❑No	**Skin/Breasts**	
Hearing changes or loss	❑Yes ❑No	Masses or lumps	❑Yes ❑No
Nosebleeds	❑Yes ❑No	Nipple discharge	❑Yes ❑No
Dizziness	❑Yes ❑No	Rashes or nonhealing ulcers	❑Yes ❑No
Respiratory		**Neurologic**	
Blood in your sputum	❑Yes ❑No	Seizures	❑Yes ❑No
Chest tightness	❑Yes ❑No	Coughing or choking with swallowing	❑Yes ❑No
Cough lasting >1 month, productive or not	❑Yes ❑No	Excessive daytime sleepiness	❑Yes ❑No
Shortness of breath	❑Yes ❑No	Extremity pain or burning sensations	❑Yes ❑No
Wheezing	❑Yes ❑No	Hallucinations	❑Yes ❑No
Chest pain with inhalation or coughing	❑Yes ❑No	Numbness or tingling	❑Yes ❑No
Cardiovascular		Difficulty falling asleep, staying asleep	❑Yes ❑No
Chest pain or heaviness	❑Yes ❑No	**Endocrinologic**	
Palpitations	❑Yes ❑No	Hair loss	❑Yes ❑No
Fainting or near fainting spells	❑Yes ❑No	Frequent urination	❑Yes ❑No
Swelling of feet or legs	❑Yes ❑No	Increased thirst	❑Yes ❑No
Shortness of breath lying flat in bed	❑Yes ❑No	Heat or cold intolerance	❑Yes ❑No
Gastrointestinal		**Heme/Lymph**	
Abdominal pain	❑Yes ❑No	Bleeding from gums or nose	❑Yes ❑No
Blood in your stool	❑Yes ❑No	Unexplained bruising	❑Yes ❑No
Constipation	❑Yes ❑No	Night Sweats	❑Yes ❑No
Diarrhea or Food Intolerance	❑Yes ❑No	Swollen, painful lymph nodes	❑Yes ❑No
Heartburn or Indigestion	❑Yes ❑No	**Allergy/Immun**	
Vomiting or nausea lasting for >1 day	❑Yes ❑No	Watery eyes	❑Yes ❑No
Swallowing difficulty	❑Yes ❑No	Runny nose	❑Yes ❑No
Psych		Food intolerance	❑Yes ❑No
Anxiety without clear explanation	❑Yes ❑No	Frequent skin sores	❑Yes ❑No
Sadness lasting for days or weeks	❑Yes ❑No		
Hearing voices	❑Yes ❑No		
Thoughts of hurting yourself	❑Yes ❑No		
Thought of hurting others	❑Yes ❑No		
Fear of people, places or things	❑Yes ❑No		

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Family Medical History
(M=Mother, F=Father, B=Brother, S=Sister, So=Son, D=Daughter, GM=Grandmother, GF=Grandfather, M in front = Maternal P = Paternal)

Medical Problem	Family Members Affected
	❑M ❑F ❑B ❑S ❑So ❑D ❑M-GM ❑M-GF ❑P-GM ❑P-GF
	❑M ❑F ❑B ❑S ❑So ❑D ❑M-GM ❑M-GF ❑P-GM ❑P-GF
	❑M ❑F ❑B ❑S ❑So ❑D ❑M-GM ❑M-GF ❑P-GM ❑P-GF
	❑M ❑F ❑B ❑S ❑So ❑D ❑M-GM ❑M-GF ❑P-GM ❑P-GF
	❑M ❑F ❑B ❑S ❑So ❑D ❑M-GM ❑M-GF ❑P-GM ❑P-GF
	❑M ❑F ❑B ❑S ❑So ❑D ❑M-GM ❑M-GF ❑P-GM ❑P-GF
	❑M ❑F ❑B ❑S ❑So ❑D ❑M-GM ❑M-GF ❑P-GM ❑P-GF

Referral Information – We would appreciate learning how you heard about us? Check one, please

❑Another physician, nurse practitioner or physician assistant?
If so, please specify who:
❑Family member or friend who is a patient of this clinic
❑Family member or friend who is NOT a patient of this clinic
❑Sign outside your office
❑Billboard Ad
❑Media Ad *Please specify* ❑Television ❑Radio ❑Newspaper Ad
❑Hospital referral service
❑Phone book
❑Internet
☐Other, *please specify*

Additional Information that you feel may be helpful for your health care provider to know.

Health Care Provider Notes

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