Health Assessment Questionnaire

Patient Name: _____ Date: _____

DOB:_____Age: _____ Sex Assigned at Birth: ☐ M ☐ F

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 ☐ Kettering Medical Center ☐ Atrium

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

Health Assessment Questionnaire

Female Reproductive Organs Only: ☐ NA

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

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: _____

Phone Number: _____ Fax: _____

Operations:

Please list any surgery and approximate year:

surgery/operation:	Year	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospitalizations:

Please list hospitalization that were not related to a

Surgery	Year	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

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: _____