GUADALUPE FAMILY HEALTH, PA

COMPREHENSIVE ADULT ESTABLISHED PATIENT HEALTH HISTORY UPDATE QUESTIONNAIRE

Please fill out completely and bring to your first appointment or fax it to our office. Please bring all medication bottles, ID, and insurance card.

This is an update form to let us know of any care given by other providers and any changes in our health status since your last annual screening exam. If you are uncomfortable with any question do not answer it. Thank you!

NAME: _____ **DATE:** _____

Main reason for today's visit: Preventative Visit (Health Maintenance Exam)

Other concerns: _____

What are your health goals for the next year? _____

How would you rate your health? (circle one) Excellent / Good / Fair / Poor

Please list healthcare providers and their specialty you see regularly: _____

_____

MEDICAL/SURGICAL HISTORY: Any major medical illnesses or surgeries since your last screening exam at our clinic? No (List here):

_____

FAMILY HISTORY UPDATE: Any **NEW** medical illnesses or deaths in your immediate family since your last screening visit? No (List here):

_____

HEALTH ISSUES:

Tobacco Use:

Smoke or smoked ☐ Yes ☐ No

Exposure to second hand smoke? ☐ Yes ☐ No

(If never used any tobacco can skip to **Alcohol**)

Current smoker: Packs/Day: _____ # of years _____

Former smoker: _____ Quit Date: _____

About how many packs/day did you smoke? _____

About how many years did you smoke? _____

Other Tobacco/Nicotine? (circle) Snuff Chew Vape

Quit Date: _____ Currently use? ☐ Yes ☐ No

Are you ready to quit? ☐ Yes ☐ No

Alcohol Use:

Do you drink alcohol ☐ Yes ☐ No

drinks/week: _____ ☐ Beer ☐ Wine ☐ Liquor

Drug Use:

Have you ever used recreational drugs? ☐ Yes ☐ No

If yes, which ones? _____

Quit which ones? _____

Occupational Risks / Exposures:

Military Service? ☐ Yes ☐ No

Blood Transfusion? ☐ Yes ☐ No

Exposure to toxic chemicals at work? ☐ Yes ☐ No

Exposure to breathing dust/particles? ☐ Yes ☐ No

Sexual Activity:

Are you sexually active? ☐ Not now ☐ Never ☐ Yes

Have you ever had a sexually transmitted infection? ☐ Yes ☐ No

Birth control method or STD prevention (check current)

☐ Not needed ☐ Condom ☐ Pill ☐ IUD ☐ Patch

☐ Ring ☐ Vasectomy ☐ Tubes Tied / Hysterectomy

☐ Rhythm Method/Periodic Abstinence

Exercise:

Do you exercise regularly? ☐ Yes ☐ No If yes, what kind of exercise? _____

How long (minutes)? _____ How often? _____

Diet:

Do you follow a special diet? ☐ Yes ☐ No If yes, which one? Vegetarian Vegan Gluten Free Other _____

Mood:

Over the last 2 weeks how often have you been bothered by the following problems?	Not at all	Several Days	More than ½ of the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				

HOME SAFETY:

Does your home have a working smoke detector? ☐ Yes ☐ No

If you have children, are any guns locked up & ammo stored separately? ☐ Yes ☐ No

Have you ever been hurt, insulted, threatened or screened at by someone in your home? ☐ Yes ☐ No

If you have fair skin, do you routinely wear UV protection to prevent skin cancer? ☐ Yes ☐ No

If you or someone in your home is unsteady, have you changed your home to prevent falls? ☐ Yes ☐ No

SOCIOECONOMIC:

Occupation (or prior occupation)_____ Employer: _____

If you are not currently working are you:

☐ Retired ☐ Unemployed ☐ On a leave of absence ☐ Disabled ☐ Homemaker ☐ Other _____

Marital status: ☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed

Spouse/partner's name: _____

Number of children: _____ Ages (if minors): _____ # of grandchildren: _____

WOMEN'S HEALTH HISTORY:

Any pregnancies since your last visit? ☐ Yes ☐ No

Total number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____

Do you have concerns about your periods or menopause you'd like to discuss? ☐ Yes ☐ No

HEALTH MAINTENANCE:

Any new medication allergies, immunization, or clinical studies done outside our clinic (for example vaccines, mammograms, colonoscopies)?

_____

_____

Thank you for taking the time to complete this form!