Horizon Family Medicine, PA
Multiple Locations With One Purpose...Your Health

Comprehensive Health Questionnaire

Name: _____ Date of Birth: _____

Address: _____

Cell Phone: _____ Home/Alternative Phone: _____

Please describe the problem or concern that brought you to our office today:

☐ New Patient ☐ Other (briefly describe) _____

▶ **SPECIAL COMMUNICATION NEEDS**					
Your language preference:					
If "yes" to any of these questions below, how can we assist?					
Visual Impairment	☐ Yes	☐ No	Cognitive Impairment	☐ Yes	☐ No
Hearing Impairment	☐ Yes	☐ No	Sensory Impairment	☐ Yes	☐ No
Speech Impairment	☐ Yes	☐ No	Mental Impairment	☐ Yes	☐ No

▶ **SOCIAL HISTORY**
Please check appropriate answers below and provide explanations where appropriate
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner
Education level: ☐ Did not graduate ☐ High school ☐ Some college ☐ Bachelor's Degree ☐ Master's Degree or higher
Your occupation:
Occupational Concerns? ☐ Stress ☐ Hazardous Substances ☐ Heavy Lifting ☐ Other? _____
How stressful would you rate your current living situation? No stress 1 2 3 4 5 6 7 8 9 10 Very stressful
Are there financial concerns that affect your ability to seek healthcare? ☐ No ☐ Yes If yes, briefly describe below
Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

▶ **FAMILY HISTORY**			**Significant Medical Problems and/or Cause of Death** *(e.g. Diabetes, Heart Disease, High Blood Pressure, Cancer, Lung Disease, Liver Disease, Stroke, Kidney Disease, Depression or Bipolar Disorder, Osteoporosis, etc.)*
Relationship	**Living? Y/N**	**Age**	
Father			
Mother			
Siblings:			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
Children:			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
Have any of your relatives had the following conditions?			
☐ Mental Illness Relative:			
☐ Chemical Dependency Relative:			

CURRENT HEALTH CONCERNS: Please check problems or conditions you are ***CURRENTLY*** experiencing

▶ **GENERAL:**	▶ **CARDIAC (heart):**	☐ Loss of interest in home and family
☐ Recent family illness or death	☐ Sleep with more than one pillow	☐ Previously had counseling or psychiatric care
☐ Any recent change in weight	☐ Chest pain	
☐ Recurrent fever or chills	☐ Swelling of ankles	
	☐ Fast or irregular heartbeat	▶ **GASTROINTESTINAL (Stomach):**
▶ **HEAD AND EYES:**	☐ Previous medication for heart	☐ Indigestion or heartburn
☐ Headaches more than once a week	☐ Past heart murmur	☐ Stomach pains
☐ Vision affected by headaches	☐ Past heart attack	☐ Vomiting blood
☐ Fainting spells	☐ High or low blood pressure	☐ Difficulty swallowing
☐ Injury to head		☐ Black or bloody bowel movements
☐ Dizziness	▶ **SKIN:**	☐ Frequent constipation
☐ Double or blurred vision	☐ Boils	☐ Rectal pain or bleeding
☐ Pain in eyes	☐ Black and blue spots without injury	☐ Intolerant of fried or fatty foods
☐ Decreased vision	☐ Cuts that are hard to heal	☐ Hepatitis
☐ Blind spots or blindness	☐ Colored moles that have recently changed	☐ Jaundice or yellowing of the skin
☐ Seeing colored halo around lights		☐ History of ulcer disease
	☐ Persistent rash	
▶ **EAR, NOSE & THROAT:**		▶ **URINARY:**
☐ Recent change in hearing	▶ **NEUROPSYCHIATRIC:**	☐ Urinate often at night
☐ Drainage from the ears	☐ Change in speech	☐ Pain or burning with urination
☐ Ringing or buzzing in the ears	☐ Losing track of thoughts	☐ Blood in the urine
☐ Head colds more than once a month	☐ Unable to express thoughts or feelings	☐ Loss of bladder control
☐ Nose bleeds for no apparent reason		☐ Urinate frequently during day (more than 5-6 times)
☐ Nasal drip without a cold	☐ Persistent numbness or tingling	
☐ Sinus problems	☐ Trouble coordinating	☐ History of kidney stones
☐ Hoarseness without a cold	☐ Loss of memory	
☐ Lumps or swelling in the neck	☐ Difficulty with words	▶ **MUSCULOSKELETAL:**
☐ Trouble swallowing	☐ Frequently ill	☐ Gout
☐ Change in voice	☐ Afraid to be alone	☐ Stiffness or pain in joints
☐ Thyroid enlargement (goiter)	☐ Finding decisions difficult	☐ Arthritis
	☐ Previously had a nervous breakdown	☐ Paralysis or weakness
▶ **RESPIRATORY (lungs):**	☐ Loss of appetite	☐ Back pain
☐ Frequent cough	☐ Unhappy with job	☐ Any type of body disability or deformity
☐ Coughing up sputum (mucus)	☐ Crying frequently	
Color_____ Amount per day _____	☐ Difficulty falling asleep	☐ More than 1" shorter than you were at age 25
☐ Coughing up blood	☐ Frequent spells of complete exhaustion	
☐ Chest colds more than twice a winter	☐ Often tired or exhausted in morning	
☐ Short of breath after walking _____ flights of stairs	☐ Severe aches/pains that make it impossible to work	▶ **ENDOCRINE (glands)**
		☐ Weight loss despite good appetite
☐ Asthma	☐ Feel unhappy and depressed	☐ Unusual loss of hair
☐ Night Sweats	☐ Life looks entirely hopeless	☐ Constantly thirsty
☐ TB exposure or past history of TB	☐ Wish that you were dead and away from it all	☐ Recent weight gain
☐ Hay Fever		☐ Craving sweets
	☐ Tremors or convulsions	☐ Hot or cold room intolerance
▶ OTHER (write in):	☐ Loss of interest in sex	
☐	☐ Currently living under tension	

▶ **WOMEN ONLY:**	▶ **MEN ONLY:**
☐ Number of pregnancies _____ Stillbirths _____ Miscarriages _____ Premature babies _____	☐ Trouble starting urinary stream
	☐ Reduced urinary stream
☐ Currently on birth control pills or hormones	☐ Cancer or tumor of the prostate
☐ Problems with pregnancy:_____ Describe: _____	☐ Lumps or sores on the penis, or discharge from the penis
☐ Babies over nine pounds at birth _____	☐ Loss of sexual ability or interest in sex
☐ Spotting between periods or after sex	☐ Rupture
☐ Not having periods now Date of last period: _____	☐ Enlarged, swollen, tender or hard testicles
	☐ A doctor informed you that your prostate is enlarged
☐ Excessive vaginal discharge	
☐ Lump or pain in breasts	
☐ Severe pain with periods	

▶ **COMMENTS ABOUT ITEMS YOU CHECKED:**

▶ **LIST OTHER THINGS YOU WOULD LIKE YOUR DOCTOR TO KNOW:**

▶ **PERSONAL HEALTH HISTORY**		▶ **PREVIOUS SURGICAL PROCEDURES**	
Please check past or current problems/conditions		Please check and list date if you have had any of the following:	
☐ Hypertension	☐ Seizures	☐ Heart surgery	Date:
☐ High cholesterol	☐ Headaches	☐ Carotid artery surgery	Date:
☐ Diabetes	☐ Stroke	☐ Vascular surgery/stent	Date:
☐ Heart attack or angina	☐ Prostate problem	☐ Abdominal aneurysm repair	Date:
☐ Irregular heart rhythm	☐ Breast problem	☐ Hysterectomy	Date:
☐Congestive heart failure	☐ Urinary tract infection	☐ Gallbladder removed	Date:
☐ Asthma	☐ Osteoarthritis	☐ Appendix removed	Date:
☐ Emphysema or chronic bronchitis	☐ Cancer (please list type)	☐ Tonsillectomy	Date:
☐ Pneumonia		☐ Joint replacement	Date:
☐ Gastroesophageal reflux disease	☐ Thyroid problem	☐ Breast cancer surgery	Date:
☐ Stomach ulcer	☐ Bleeding disorder	☐ Hernia	Date:
☐ Kidney problems	☐ Addiction issues	☐ Pacemaker	Date:
☐ Liver disease/hepatitis	☐ Depression anxiety	☐ Other: (describe and list date)	
☐ Colon cancer	☐ Mental illness		
☐ Bowel/digestive problem	☐ Other: (describe)		

▶ **ALLERGIES:** *Please list any allergies to medications or foods*	

▶ **ANY OTHER INFORMATION YOU WOULD LIKE YOUR DOCTOR TO KNOW:**

▶ **MEDICATIONS:** *Please list any medications you take, including over-the-counter, herbs and supplements. Include the dose and frequency.*	

▶ **HEALTH MAINTENANCE:** *Please check if you have had the following preventive services. Please list year of service.*					
Immunizations		**Year**	**Tests**		**Year**
Tetanus vaccine/Tdap	☐ Yes ☐ No		Pap smear/pelvic	☐ Yes ☐ No	
Pneumonia vaccine	☐ Yes ☐ No		Mammogram	☐ Yes ☐ No	
Influenza vaccine	☐ Yes ☐ No		Bone density scan	☐ Yes ☐ No	
Shingles vaccine	☐ Yes ☐ No		Colonoscopy	☐ Yes ☐ No	
			Prostate test	☐ Yes ☐ No	

▶ **HEALTH BEHAVIORS**			
Tobacco use: ☐ Never ☐ Quit (when) _____ ☐ Current smoker ☐ Currently chew tobacco ☐ Snuff			
If current smoker, how many packs per day? _____ for how many years? _____			
If currently using chewing tobacco, for how long? _____			
Alcohol intake: ☐ None ☐ Yes If yes, how many drinks?_____ and how often? _____			
Illicit drug use (including marijuana, cocaine, steroids, etc.) ☐ Never ☐ Past ☐ Current			
If current illicit drug user, please describe:			
Exposure to second hand smoke	☐ Yes ☐ No	Wear a seatbelt	☐ Yes ☐ No
Eat a diet high in fruits and vegetables	☐ Yes ☐ No	See dentist at least once per year	☐ Yes ☐ No
Get 30 minutes of exercise 5 times a week	☐ Yes ☐ No	Wear sunscreen	☐ Yes ☐ No

▶ **SPECIALTY PROVIDERS:** *So that we can best coordinate your care, please list any medical providers you see outside of this practice and the year you last saw them.*			
☐ Eye doctor	Year last seen:	☐ Neurologist	Year last seen:
☐ Cardiologist	Year last seen:	☐ Psychiatrist	Year last seen:
☐ Oncologist	Year last seen:	☐ Allergist	Year last seen:
☐ Urologist/Gynecologist	Year last seen:	☐ Vascular	Year last seen:
☐ Gastroenterologist	Year last seen:	☐ Pulmonologist	Year last seen:
☐ Endocrinologist	Year last seen:	☐ Other	Year last seen:

▶ **ADVANCE CARE PLANNING:** *Do you currently have, or would you like information on any of the following items:*			
☐ Living Will	☐ Have	☐ Don't have	☐ Would like information
☐ Durable Power of Attorney	☐ Have	☐ Don't have	☐ Would like information
☐ DNR ("Do Not Resuscitate")	☐ Have	☐ Don't have	☐ Would like information
☐ Other:			

▶ **FALL RISK SCREENING**	
☐ Have you fallen within the last 12 months?	☐ Yes ☐ No ☐ Unsure
☐ If yes, how many times?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
☐ Were you injured as a result of this fall?	☐ No ☐ Yes If yes, please briefly describe injury:

▶ **MOOD SCREENING:** *A person's mood can have a strong influence on their health status and overall wellbeing. Over the past two weeks, how often have you been bothered by any of the following problems?*

Little interest or pleasure in doing things:	**Feeling down, depressed or hopeless:**
☐ Not at all	☐ Not at all
☐ Several days	☐ Several days
☐ More than half the days	☐ More than half the days
☐ Nearly every day	☐ Nearly every day

▶ **HEALTH LITERACY QUESTIONNAIRE:** *Sometimes healthcare staff and providers use words that are unfamiliar to the general population. Please rate the following questions on a scale of 1 to 10, with 1 being Strongly Disagree and 10 being Strongly Agree*

	Strongly Disagree								Strongly Agree
I feel that I have a thorough understanding of the instructions my doctors and nurses give me about health	1	2	3	4	5	6	7	8	9	10
I feel that, after I return home, I remember the instructions given to me at my doctor's office	1	2	3	4	5	6	7	8	9	10
I feel that I have a good understanding of medical language	1	2	3	4	5	6	7	8	9	10

▶ **HOW ARE YOU DOING?**
Do you spend time with family and/or friends? ☐ Frequently ☐ Occasionally ☐ Rarely
Do you participate in social activities? ☐ Frequently ☐ Occasionally ☐ Rarely
Have you recently felt isolated from other people? ☐ Frequently ☐ Occasionally ☐ Rarely
Have you recently had difficulty performing daily tasks? ☐ Frequently ☐ Occasionally ☐ Rarely
Do you have regular access to nutritional food? ☐ Frequently ☐ Occasionally ☐ Rarely
Do you have transportation for medical appointments and other activities? ☐ Always ☐ Most of the time ☐ Rarely
Do you miss doctor appointments because you have no means of travel? ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never
* If you use the internet, please visit our website at horizonfamilymed.com for information about resources available to you. And, look for the Community Resources flyer posted in your clinic's lobby- it also lists the resources!

Patient Signature: _____ Date: _____

Legal Representative Signature (if applicable) _____ Date: _____