

**Godwin Family Practice
Health History Questionnaire**

The purpose of this questionnaire is to aid us in providing quality health care. Please complete the questions as accurately as possible (print legibly). *This questionnaire and your entire clinical record are strictly confidential and will not be released to anyone without your written consent/signature.*

Name: _____ Today's Date: _____

Date of Birth: ____-____-____ Sex: M F Age: _____ Soc. Sec. # _____

Maiden Name: _____ Marital Status: Single Married Widowed Divorced

Address: _____

Phone: _____ Cell: _____

Employer Name: _____ Employer Phone Number: _____

Employer Address: _____

INSURANCE:

•Primary Ins: _____

•Secondary Ins: _____

ID#: _____

ID#: _____

Subscriber Name: _____ DOB _____

Subscriber Name: _____ DOB _____

Phone #: _____

Phone #: _____

Emergency Contact Name: _____ Relationship: _____

Address: _____ Phone Number: _____

Family Physician, Nurse Practitioner, Physician Asst. _____

Phone Number: _____

Local Pharmacy: _____ Circle 1 month or 3 month mail-in prescription

CURRENT MEDICATIONS: Please list any *prescription and over-the-counter medications* (including herbal remedies and nutritional supplements) you are currently taking. Please include:

Name of Medication	Dosage	How Often	What Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT MEDICATIONS: (continued)

Name of Medication	Dosage	How Often	What Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DRUG/MEDICATION ALLERGIES: Please list all *prescription* and/or *over-the-counter* allergies. Also state the *type of allergic reaction* (i.e., skin — rash, hives; respiratory — difficulty breathing, etc.) If none, state none.

OTHER ALLERGIES: Please list any other environmental, food, or product allergies (i.e., latex) you may have and the type of reaction. If none, state none.

YOUR PERSONAL MEDICAL HISTORY: Have you ever been diagnosed by a Physician or other Healthcare Provider with the following?

Alcoholism/Drug Dependency	Yes	No		
Asthma or Allergies	Yes	No	Heart attack, angina, aneurysm	Yes No
Attention Deficit Disorder	Yes	No	Stroke	Yes No
Autism	Yes	No	Migraines, chronic pain, fatigue	Yes No
Anxiety, Stress	Yes	No	Other nervous or mental conditions	Yes No
Bladder or Urinary Tract Disorder	Yes	No	Organ transplant	Yes No
Bone, muscle or nerve disorders	Yes	No	Disease/disorder of prostate	Yes No
High cholesterol/triglycerides	Yes	No	Disease/disorder of female organs	Yes No
Cancer, at what age _____	Yes	No	Neck or back pain	Yes No
Cerebral Palsy	Yes	No	Disease/disorder of skin	Yes No
Chest Pain	Yes	No	Disease/disorder of stomach	Yes No
Diabetes or hypoglycemia	Yes	No	Hepatitis A B C	Yes No
Down Syndrome	Yes	No	Hyperthyroidism, hypothyroidism	Yes No
Epilepsy or seizures	Yes	No	Kidney disease	Yes No
Hypertension/high blood pressure	Yes	No	Liver disorder (including Cirrhosis)	Yes No
Heart Disease or heart surgery	Yes	No	Lung disorders or disease	Yes No
Heart Attack, angina aneurysm	Yes	No	Multiple Sclerosis	Yes No
Muscular Dystrophy	Yes	No	Parkinson Disease	Yes No
Pancreas disorders or disease	Yes	No	Spine disorders or disease	Yes No

YOUR PERSONAL MEDICAL HISTORY: *(continued)*

If you answered yes to any of the above, please explain: _____

Have you ever been hospitalized? Yes No If yes, please give date(s) and reason(s):

Have you ever had surgery? Yes No If yes, please give type(s) and date(s):

SOCIAL HISTORY:

Type of work: _____

Are you disabled and/or handicapped in any way? Yes No If yes, please explain:

Do you smoke cigarettes? Yes No If yes, how many per day and how many years? _____

- Have you ever smoked? Yes No

Do you chew tobacco? Yes No If yes, how much per day and how many years? _____

- Have you ever chewed tobacco? Yes No

Do you drink alcohol? Yes No If yes, type/amount and how many years: _____

- Have you ever drunk alcohol? Yes No
- Has anyone ever suggested you should cut back on your consumption of alcohol? Yes No
- Has anyone ever become annoyed at you when you are drinking? Yes No
- Have you ever gotten into legal trouble because of your drinking? Yes No
- Do you need an "eye opener" or a drink first thing in the morning? Yes No

Do you use street drugs? Yes No If yes, type/amount and how many years: _____

- Have you ever used street drugs? Yes No

Are you satisfied with your weight? Yes No (please explain) _____

FAMILY MEDICAL HISTORY: (blood relatives only)

	Mother	Father	G'Father	G'Mother	Sibling	
			Paternal	Maternal	Paternal	Maternal
• Alcoholism/Drug Dependency	Yes	No				
• Asthma or Allergies	Yes	No				
• Attention Deficit Disorder	Yes	No				
• Autism	Yes	No				
• Anxiety, Stress	Yes	No				
• Bladder or Urinary Tract Disorder	Yes	No				
• Bone, muscle or nerve disorders	Yes	No				
• High cholesterol/triglycerides	Yes	No				
• Cancer, kind _____	Yes	No				
• Cerebral Palsy	Yes	No				
• Chest Pain	Yes	No				
• Diabetes or hypoglycemia	Yes	No				
• Down Syndrome	Yes	No				
• Epilepsy or seizures	Yes	No				
• Hypertension/high blood pressure	Yes	No				
• Heart Disease or heart surgery	Yes	No				
• Heart attack, angina, aneurysm	Yes	No				
• Stroke	Yes	No				
• Migraines, chronic pain, fatigue	Yes	No				
• Other nervous or mental conditions	Yes	No				
• Organ transplant	Yes	No				
• Disease/disorder of prostate	Yes	No				
• Disease/disorder of female organs	Yes	No				
• Neck or back pain	Yes	No				
• Disease/disorder of skin	Yes	No				
• Disease/disorder of stomach	Yes	No				
• Hepatitis A B C	Yes	No				
• Hyperthyroidism, hypothyroidism	Yes	No				
• Kidney disease	Yes	No				
• Liver disorder(including Cirrhosis)	Yes	No				
• Lung disorders or disease	Yes	No				
• Multiple Sclerosis	Yes	No				
• Muscular Dystrophy	Yes	No				
• Parkinson Disease	Yes	No				
• Pancreas disorders or disease	Yes	No				
• Spine disorders or disease	Yes	No				

HEALTH MAINTENANCE:

Females:

- Last gynecological exam (Pap) and results: _____
- Have you ever had an abnormal Pap smear? Yes No If yes, treatment rendered: _____
- Last clinical breast exam: _____
- Do you do self breast exams? Yes No
- Do you take a calcium supplement: Yes No How much? _____

HEALTH MAINTENANCE: Females (continued)

- Have you had a Bone Density test: Yes No When and where? _____
 - Have you ever had a mammogram? Yes No When and where? _____
 - Have you ever had an abnormal mammogram? Yes No If yes, treatment rendered: _____
 - Do you have heavy menstrual cycles? Yes No
 - Have you been treated for Endometriosis? Yes No
 - Have you ever had irregular menstrual history? Yes No
 - Have you had a hysterectomy? Yes No
-

Males:

- Last prostate exam and results: _____
- Last PSA laboratory test: _____
- Abnormalities with either: _____ Treatment rendered: _____
- BPH Yes No
- Erectile Dysfunction Yes No

Males/Females:

- Last health exam/results: _____
- Last blood work: _____ what was checked? _____
- Last vision exam/results: _____
- Last dental exam/results: _____
- Last tetanus shot: _____
- Do you have annual flu shot: _____
- Have you ever had Pneumovax (pneumonia) vaccine: Yes No
- Have you ever had a Colonoscopy? Yes No If yes, what reason, when, and what were the results? When was follow-up recommended? _____
- Do you take daily multivitamin? Yes No
- Do you take aspirin daily? Yes No
- Childhood immunizations up to date?: _____ Where given _____
- Do you exercise regularly? Yes No How often and what type? _____

Diabetic Patients only:

- How often do you check your blood sugar? _____
- Average fasting blood sugar: _____
- Last dilated diabetic eye exam: _____
- Do you check your feet regularly? Yes No

REVIEW OF SYSTEMS: (Please circle or underline)

General/Constitutional

Average weight, weight loss or gain, general state of health, sense of well-being, strength, ability to conduct usual activities, exercise tolerance

Skin/Breast

Rash, itching, pigmentation, moisture or dryness, texture, changes in hair growth or loss, nail changes
Breast lumps, tenderness, swelling, nipple discharge

Eyes/Ears/Nose/Mouth/Throat

Headaches (location, time of onset, duration, precipitating factors), vertigo, lightheadedness, injury

REVIEW OF SYSTEMS: (continued)

Vision, double vision, tearing, blind spots, pain
Nose bleeding, colds, obstruction, discharge
Dental difficulties, gingival bleeding, dentures
Neck stiffness, pain, tenderness, masses in thyroid or other areas

Cardiovascular

Precordial pain, substernal distress, palpitations, syncope, dyspnea on exertion, orthopnea, nocturnal paroxysmal dyspnea, edema, cyanosis, hypertension, heart murmurs, varicosities, phlebitis, claudication

Respiratory

Pain (location, quality, relation to respiration), shortness of breath, wheezing, stridor, cough (time of day, of productive, amount in tablespoons or cups per day and color of sputum), hemoptysis, respiratory infections, tuberculosis (or exposure to tuberculosis), fever or night sweats

Gastrointestinal

Appetite, dysphagia, indigestion, food idiosyncrasy, abdominal pain, heartburn, eructation, nausea, vomiting, hematemesis, jaundice, constipation, or diarrhea, abnormal stools (clay-colored, tarry, bloody, greasy, foul smelling), flatulence, hemorrhoids, recent changes in bowel habits

Genitourinary

Urgency, frequency, dysuria, nocturia, hematuria, polyuria, oliguria, unusual (or change in) color of urine, stones, infections, nephritis, hesitancy, change in size of stream, dribbling, acute retention or incontinence, libido, potency, genital stores, discharge, venereal disease

(Female) Age of onset of menses, regularity, last period, dysmenorrhea, menorrhagia, or metrorrhagia, vaginal discharge, post-menopausal bleeding, dyspareunia, number and results of pregnancies (gravida, para)

Musculoskeletal

Pain, swelling, redness or heat of muscles or joints, limitation, of motion, muscular weakness, atrophy, cramps

Neurologic/Psychiatric

Convulsions, paralyzes, tremor, incoordination, parathesias, difficulties with memory of speech, sensory or motor disturbances, or muscular coordination (ataxia, tremor)

Predominant mood "nervousness" (define), emotional problems, anxiety, depression, previous psychiatric care, unusual perceptions, hallucinations

Allergic/Immunologic/Lymphatic/Endocrine

Reactions to drugs, food, insects, skin rashes, trouble breathing

Anemia, bleeding tendency, previous transfusions and reactions, Rh incompatibility

Local or general lymph node enlargement or tenderness. -Polydipsia, polyuria, asthenia, hormone therapy, growth, secondary sexual development, intolerance to heat or cold

1. **Release of Information** — Authorization is hereby granted to the Godwin Family Practice to release to all appropriate third party payors, including patient's insurance companies (including insurance companies' reviewer under control), such information as may be deemed necessary in the completion of an admission of a patient. The undersigned understands this authorization may be revoked at any time, but not retroactive to the release of information made in good faith, on the condition that the Godwin Family Practice is informed in writing of such revocation.

2. **Assignment** — I hereby assign to Godwin Family Practice all medical benefits now due and payable to me under any applicable insurance policies (including governmental reimbursements), and hereby direct any insurance companies or governmental agencies to pay such benefits directly to said establishment and services furnished by said establishment.

3. **Financial Responsibility** — I/we understand that I/we remain financially responsible to the Godwin Family Practice for all charges incurred. I/we also understand the charges are due and payable at the time of service.

I hereby authorize the Godwin Family Practice to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper medical care. The information on this page is correct to the best of my knowledge.

Signature: _____

Date: _____

Adult Patient _____ Parent _____ Guardian _____