EAST GRAND HEALTH CENTER

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Prospective Patient Health Questionnaire

Name: _____Age_____Sex_____
Date of Birth _____Phone_____Cell_____
Occupation_____
Marital Status (circle) Single Married Widowed Divorced Separated

A. Do you have children (circle) Yes if yes how many? Sons_____Daughters_____
No

B. List allergies to medicines, food, etc_____
C. List all medications you take regularly, including over the counter. (You may also provide a list)
_____
_____

D. Do you currently smoke/chew tobacco or have you ever smoked tobacco? (circle) Yes No
If yes, how much do or did you smoke? _____ Age you began smoking _____
When did you quit? _____
E. How many drinks containing alcohol do you have on a typical day? _____
F. Do you use recreational drugs? (circle) Yes if yes, what _____
No

G. Have you used drugs in the past? (circle) Yes if yes, what _____
No

H. Do you consume caffeine? (circle) Yes No
If yes, what form and how much per day (cups/soda, cans) _____

I. Sleep (hours per night)_____-- Exercise (hours per week) _____

J. Illness Check any that apply to you:
___Diabetes ___Heart Trouble ___Ulcers ___Cancer
___High Blood Pressure ___High Cholesterol ___Bowel Disease ___Kidney/bladder
___Gland Disease (thyroid) ___Serious infections ___Ear/Eye Trouble ___Nervous condition
___Lung Disease (Asthma, COPD) Other_____

K. Serious injuries _____
Operations _____
Hospitalizations: When and What for? _____
_____

L. Are your immunizations up to date? (Circle) Yes No Unknown

M. **Family History:** Please indicate which member of the family.

_____Diabetes
_____Cancer
_____High Cholesterol
_____Blood Disease
_____Ulcers
_____Nervous Condition
_____High Blood Pressure
_____Heart trouble
_____Bowel Disease
_____Ear or Eye Trouble
_____Lung Disease
_____Kidney Diseases
_____Psychiatric Illness

N. **Health History:** Check any of the following that have been a problem for you in the last year.

Respiratory
___sneezing or gasping
___coughing
___daily cough
___cough up phlegm
___frequent chest cold
___excessive sweating

Cardiovascular
___rapid heartbeat
___chest pains
___dIzzy spells
___shortness of breath
___swollen feet/ankles
___leg cramps
___heart murmurs

Digestive
___pain in rectum
___bloated stomach
___stomach pain
___vomiting blood
___difficulty swallowing
___constipation
___loose bowels
___black stools/rectal bleeding
___gray stools
___heartburn

Ears
___trouble hearing
___earaches
___discharge
___ringing in ears
___motion sickness

Nose and Throat
___poor sense of smell
___congested nose
___running nose
___frequent head colds
___nose bleeds

Mouth
___bleeding gums
___dental problems
___swelling of gums/jaws
___sore tongue
___taste changes
___enlarged tonsils
___hoarse voice

Skin
___cysts or lumps
___itching or burning
___acne
___easy bleeding
___easy bruising

Eyes
___glasses
___blurred vision
___eyesight worse
___double vision
___see halos
___eye pain or itch
___watery eyes

Neurological
___fainting
___numbness
___convulsions
___convulsions or fits
___changes in handwriting

Musculoskeletal
___aching/muscles/joints
___swollen joints
___weakness

Urinary
___frequent urination
___burning on urination
___bloody urine
___difficulty-starting urine
___urgency
___urine leakage (incontinence)

Emotional
___low mood
___mood swings
___increase tearfulness
___no motivation
___hallucinations
___panic attacks
___anxiety

General
___weight change
___sleeping difficulties
___increased fatigue
___increased/decreased appetite
___night sweats

For Women Only
___painful periods
___lumps in breast(s)
___bleeding between periods
___vaginal discharge
___hot flashes

Method of birth control_____
Last PAP_____
Previous abnormal pap_____
Last Mammogram_____

Please note any medical conditions that were not covered on this questionnaire: (You may also choose to give more details on any items checked above:_____
_____
_____
_____
_____

Patient signature:_____ **Date:**_____
(Parent/Guardian if under 18 years of age)

Name of former practice: _____

Name of former Provider _____

Date you left practice: _____

Reason for leaving prior practice_____

How long had you been in the practice_____

Patient Signature: _____ Date:_____
Parent/guardian if under 18 yrs of age