Victor Health Associates

6532 Anthony Drive, Suite A, Victor, NY 14564

Health History Questionnaire

Name: _____ **DOB: _____**
Phone Home: _____ **Phone Cell: _____**
Date of Physical Appointment: _____

Instructions: Please answer the following questions to the best of your ability. This questionnaire should take 10-15 minutes to complete. Please complete this prior to your arrival for the physical.

Please identify any major health concerns you have: _____

_____

Family information

1) Marital Status (circle): Single Engaged Married Divorced Widowed Significant Other

2) Name of Spouse/Significant Other: _____

3) Children's' Names and Ages: _____

_____

Nutrition and Physical Activity

4) What is your best estimate of the number of servings of each of these foods you have daily?

Fruits/Vegetables	_____/day
Fiber	_____/day
High Fat/Junk Food	_____/day
Sweetened Beverages (non-diet)	_____/day

5) How many days per week do you exercise?_____ How long do you exercise (in minutes) _____/day

Employment

6) What is your occupation? _____

7) Have you ever been exposed to radiation/radioactive materials at work? □Yes □No

8) Have you been exposed to any harsh chemicals/irritants at work? □Yes □No
Type: _____

Activities of Daily Living and Support

9) In the past 7 days, have you required assistance from others to perform everyday activities such as eating, getting dressed, bathing/showering, using the toilet or walking? □Yes □No

10) In the past 7 days, have you required assistance from others to take care of tasks such as laundry and housekeeping, banking, shopping, paying bills, food preparation, transportation, using the telephone or taking your medications? □Yes □No

11) Have you had any falls in the past year? □Yes □No

12) Do you use any assistive devices to help you get around? (If yes circle type) □Yes □No
Cane Walker Scooter Wheelchair Other: _____

Advance Directives

13) Do you have any form of Advanced Directives for your medical care in the instance that you are incapacitated? (circle) □Yes □No

Living Will Health Care Proxy Do Not Resuscitate Do Not Intubate

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Personal/Safety/Sexual History

14) How often do you wear a seat belt when driving or riding in a car or truck?
Always Usually Sometimes Seldom or Never

15) Do you feel unsafe with your partner/significant other? □Yes □No

16) Have you ever been hit/punched/slapped/kicked/pushed by anyone in your household? □Yes □No

17) Have you ever been sexually, verbally, or emotionally abused? □Yes □No

18) Are there guns in the home? □Yes □No

19) Do you have more than one sexual partner? □Yes □No

20) Have you ever been with a prostitute? □Yes □No

Tobacco/Alcohol/Drug History

21) Do you smoke cigarettes (now or in the past)? □Yes □No
How much:_____packs per day How long:_____years Quit when: _____

22) Do you smoke a pipe or cigar or use smokeless/oral tobacco? □Yes □No

23) If you smoke or use tobacco products, are you interested in quitting in the next month? □Yes □No

24) How many alcoholic drinks do you consume (beer, wine, liquor) _____/week

25) Has drinking alcohol ever caused health, legal, driving, family or work issues? □Yes □No

26) Do you have any family members with drinking problems? □Yes □No

27) Have you ever used illegal or illicit drugs or have you used prescription medications to get high? □Yes □No
(If yes circle which)
Cocaine Heroine Marijuana LSD/Acid Anabolic Steroids Pain Meds

Personal Health Information

28) Have you ever been told you have a polyp of the colon? □Yes □No

29) Have you ever had a blood transfusion? □Yes □No

30) Have you ever had Shingles? □Yes □No

31) Are you Currently using Birth Control? Type: _____ □Yes □No

32) Have you ever been exposed to someone with tuberculosis? □Yes □No

Medication/Drug History

33) Please review the e attached medication and allergy list and please add any prescription medications, supplements, herbal medications, over the counter medications and allergies that are not listed.

_____

_____

Specialist and Care Providers

34) Please list the name and specialty of any other providers you may see. Also list the date of your last visit with that particular provider. If diabetic, include specialists such as endocrinologist and ophthalmologist.

_____

_____

_____

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35) ***Review of Systems:*** *Please indicate any symptoms which you have had in the past year or now.*

	Past Year	Now		Past Year	Now
Prolonged Fever			Irregular or Rapid Heart Beat		
Unintentional Weight Loss			Chest Pain		
Weight Gain			Swelling in Legs or Feet		
Excessive Tiredness/Sleepiness			Leg Cramps with Exercise		
Difficulty Sleeping			Blue Discoloration in Feet		
Snoring			Loss of Appetite		
Frequent or Severe Headaches			Heartburn		
Loss of Consciousness			Nausea		
Seizures			Vomiting		
Weakness or Paralysis			Difficulty with Swallowing		
Tingling or Numbness			Diarrhea		
Dizziness			Constipation		
Loss of Balance			Black tarry or Bloody Stools		
Eye Pain			Blood in Vomit		
Blurred Vision or Vision Loss			Abdominal Pain		
Loss of Hearing			Yellow Discoloration of Skin		
Nasal Congestion			Bladder Control Problems		
Toothache			Pain with Sex		
Chronic Sore Throat			Pain or Swelling of Testicles		
Hoarse Voice			Sores or Discharge from Penis		
Swollen Glands			Prolonged/Heavy Periods		
Chronic Cough			Vaginal Discharge		
Wheezing			Hot Flashes		
Productive Cough			Pain or Lumps in Breasts		
Shortness of Breath			Non-healing Skin Sore		
Cold/Heat Intolerance			Mole that Changed		
Frequent Urination			Skin Lumps		
Excessive Thirst			Rash		

36) Any other concerns/symptoms: _____

For Women Only

37) Name of OB/GYN: _____ Date of Last Visit: _____

38) Number of: Pregnancies: _____ Deliveries: _____ Miscarriages: _____

Vaginal Deliveries: _____ C-Sections: _____

39) Date of your last menses: _____

40) Have you had a Hysterectomy? (Circle type and print date if yes) □Yes □No

Complete with removal cervix (ovaries removed) Partial (ovaries still present)

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41) ***Family History***

	Father	Mother	Siblings	Children
Alive (Yes/No)				
Ages (or Age of Death)				
Health Problems or Cause of Death				

42) Identify Health problems which your family members, living or deceased, have had:
(Identify with M=Mother, F=Father, S=Sister, B=Brother, GM=Grandmother, GF=Grandfather)

Cancers
Breast _____
Ovarian _____
Colon _____
Prostate _____
Skin _____
Other Cancers _____

Stroke/TIA _____
Diabetes _____
Heart Disease _____
Kidney Disease _____
High Cholesterol _____
Thyroid Disease _____

Bleeding Tendency _____
High Blood Pressure _____
Anesthesia Complications _____
Glaucoma _____
Mental Illness _____
Other _____
_____

Health Maintenance

43) Last Dental Appointment/Exam? Date: _____ Where: _____
44) Last Eye Exam? Date: _____ Where: _____
45) Last Pap/Pelvic? Date: _____ Where: _____
46) Last Complete Physical Exam? Date: _____ Victor Health Assoc. Other
47) Last Mammogram? Date: _____ Where: _____
48) Last Colonoscopy? (50yrs+) Date: _____ Where: _____
49) Please list any surgeries you have had and the dates:
50) Please list any hospitalizations you have had with the reason and dates:

51) What are your health goals for the next year to improve your health and overall well-being?

_____

_____

Signature of Patient: _____ Date _____
Printed Name: _____

To be completed by Nurse:

Td/Tdap _____	Flu _____	Colonoscopy _____	Chest X-ray _____
Hepatitis A _____	Pneumovax _____	Mammogram _____	Stress Test _____
Hepatitis B _____	Zostavax _____	Dexa _____	EGD _____
			Podiatry _____

PHQ-9 (Adult)

Dear Patient,

National guidelines recommend that we administer this Patient Health Questionnaire as a tool to identify common issues among our adult patients.

The answers you give are confidential, and will be reviewed by a provider and then placed in your medical chart. If you have any questions or concerns regarding this, please feel tree to address them during your office visit.

Please fill out as much as possible and sign bottom of page:

Name: _____ Date: _____

DOB: _____ / _____ / _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and mark your response.

	Not at All	Several Days	More than ½ the days	Nearly Every day
	0	1	2	3
Little Interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling asleep, staying asleep or Sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, or feeling that you are a failure, Or feeling that you have let yourself or your family down				
Trouble concentrating on things such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
Thinking that you would be better off dead or that you want to hurt yourself in some way				

If you marked any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
0	1	2	3

Patient Signature: _____

This section is for office use only: Initial/Sign:

0-4 None 5-9 Mild 10-14 Moderate 15-19 Moderate Severe 20-27 Severe