Health History Questionnaire: Larry F. Berman, M.D.

☐ **Initial** ☐ **Annual**

Name_____ Date of birth_____

Address_____

Local phone number_____ Alternative phone number_____

Preferred Pharmacy_____ Pharmacy phone number_____

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

☐ Primarily to establish care ☐ Other (please briefly describe:

Special Communication Needs: Requires Updating Annually			
Language preference:			
If 'yes' to any of the 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**	**Other:**	

Personal Health History		**Previous Surgical Procedures**	
Please check past or current problems or conditions		**Please check if you have had any of the following**	
Condition	**Condition**	**Procedure**	**Year**
☐ **Hypertension**	☐ **Seizures**	☐ **Heart surgery**	
☐ **High cholesterol**	☐ **Headaches**	☐ **Carotid artery surgery**	
☐ **Diabetes**	☐ **Stroke**	☐ **Vascular surgery / stent**	
☐ **Heart attack or angina**	☐ **Prostate problem**	☐ **Abdominal aneurysm repair**	
☐ **Irregular heart rhythm**	☐ **Breast problem**	☐ **Hysterectomy**	
☐ **Congestive heart failure**	☐ **Urinary tract infections**	☐ **Gallbladder removed**	
☐ **Asthma**	☐ **Osteoarthritis**	☐ **Appendix removed**	
☐ **Emphysema or chronic bronchitis**	☐ **Cancer (Please list type)**	☐ **Tonsillectomy**	
☐ **Pneumonia**	☐ **Thyroid problem**	☐ **Joint replacement**	
☐ **Gastroesophageal reflux disease**	☐ **Bleeding disorder**	☐ **Breast cancer surgery**	
☐ **Stomach ulcer**	☐ **Addiction Issues**	☐ **Prostate cancer surgery**	
☐ **Kidney problems**	☐ **Depression or anxiety**	☐ **Hernia**	
☐ **Liver disease/hepatitis**	☐ **Mental Illness**	☐ **Pacemaker**	
☐ **Colon cancer**	☐ **Other (please describe)**	☐ **Other (please describe)**	
☐ **Bowel/digestive problem**			
☐ **No Change since Previous Year**			

Family History			
Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically have any of your relatives had the following conditions			
Condition	Relative	Condition	Relative
☐ Mental illness		☐ Chemical dependency	

ALLERGIES: Please list any allergies to medications or foods	

Specialty Providers: Requires Updating Annually	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice and list the year that you last saw them	
☐ **Eye doctor**	☐ **Nephrologist**
☐ **Cardiologist**	☐ **Psychiatrist**
☐ **Oncologist**	☐ **Allergist**
☐ **Urologist / Gynecologist**	☐ **Vascular**
☐ **Gastroenterologist**	☐ **Pulmonologist**
☐ **Endocrinologist**	☐ **Other**
☐ **No new specialist visits since previous year**	

Please list any new medications prescribed by specialists or providers other than your PCP. Please include name, dose and frequency	

It is very important that you take the medication(s) your health care professional has given you. Please check any of the below

Are you unable to fill your prescription(s) because of the cost ☐ **Yes** ☐ **No**

Are you unable to fill your prescriptions because of lack of transportation ☐ **Yes** ☐ **No**

Have you ever applied for any pharmacy assistance ☐ **Yes** ☐ **No**

Social History: Initial
Please circle 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**
Job concerns: ☐ **Stress** ☐ **Hazardous substances** ☐ **Heavy lifting** ☐ **Transportation**
How stressful would you rate your current living situation: (Circle number) **Not Very Stressful 0 1 2 3 4 5 6 7 8 9 10 Very Stressful** **Do you fear for your safety in your current living situation?** ☐ **No** ☐ **Yes If yes, describe below**
Are there financial concerns that affect your ability: 1) to go to the doctor ☐ **No** ☐ **Yes If yes, describe:** **2) to obtain food and shelter** ☐ **No** ☐ **Yes If yes, describe:**
Are there any religious or cultural Living factors that you would like us to take into account when planning your healthcare? ☐ **No** ☐ **Yes If yes, describe:** **Do you currently have or would you like information on any of the following items:** **Living Will Information:** ☐ **Have** ☐ **Don't Have** ☐ **Want** **Durable Power of Attorney:** ☐ **Have** ☐ **Don't Have** ☐ **Want** **DNR Order:** ☐ **Have** ☐ **Don't Have** ☐ **Want**

Patient Signature:_____ Date:_____

Provider reviewed:_____ Date:_____

Preventive Health Screening

☐ **Initial** ☐ **Annual**

Name_____ Date Completed _____

Address_____

Local phone number_____ Alternative phone number_____

Preferred Pharmacy_____ Pharmacy phone number_____

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

Health Literacy Questionnaire	
It is really important to your provider that you understand the information related to your health. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree	
I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my health	**1 2 3 4 5 6 7 8 9 10**
I feel that I remember the instructions given to me at my doctor's office when I get home	**1 2 3 4 5 6 7 8 9 10**
I feel that I have a strong understanding of medical language	**1 2 3 4 5 6 7 8 9 10**

Health Maintenance:							
Please check whether you have had the following preventive services and enter the year of the 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 dexascan**	☐ **Yes** ☐ **No**	
Shingles vaccine	☐ **Yes**	☐ **No**			**Colonoscopy**	☐ **Yes** ☐ **No**	
					Prostate test	☐ **Yes** ☐ **No**	
Additional Vaccines taken since previous year		☐ **Yes**	☐ **No**	**If yes, list vaccine name and date**			

Health Behaviors: Requires Updating Annually for 11 years and older				
Tobacco use: ☐ **Never** ☐ **Quit (when)_____** ☐ **Current smoker**				
If current smoker how many packs per day for how many years_____				
Alcohol intake: ☐ **No** ☐ **Yes** **If yes how many drinks/how often_____**				
Illicit drug use (including marijuana, cocaine, steroids): ☐ **Never** ☐ **Past** ☐ **Current**				
If past or current drug use describe:				
Exposure to secondhand smoke	☐ **Yes**	☐ **No**	**Wear a seatbelt**	☐ **Yes** ☐ **No**
Eat a diet high in fruits and vegetables	☐ **Yes**	☐ **No**	**See a dentist at least once a year**	☐ **Yes** ☐ **No**
Get 30 minutes of exercise 5 times a week	☐ **Yes**	☐ **No**	**Wear sunscreen**	☐ **Yes** ☐ **No**

Urinary Incontinence Assessment: Requires Updating Annually for 65 years and older				
Do you experience leaking in the following situations:	**Not at all**	**A little**	**Sometimes**	**A lot**
During daily activities (work, household task)	☐	☐	☐	☐
During physical activities (walking, swimming, or other exercise)	☐	☐	☐	☐
During recreational activities (movies, hobbies)	☐	☐	☐	☐
During social activities (going out with friends, family visits)	☐	☐	☐	☐
During car trips	☐	☐	☐	☐

Fall Risk Screening: Requires Updating Annually for 65 years and older	
In the last 12 months have you fallen?	☐ Yes ☐ No ☐ Unsure
If yes, how many times?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
Were you injured as a result of this fall?	☐ Yes ☐ No ☐ Unsure

Functional Assessment: Requires Updating Annually for 65 years and older				
Do you need assistance in the following areas?	Not at all	A little	Sometimes	A lot
Bathing, dressing and grooming	☐	☐	☐	☐
Daily activities (cooking, cleaning other household tasks)	☐	☐	☐	☐
Walking or driving	☐	☐	☐	☐
Communicating needs and feelings	☐	☐	☐	☐
Understanding directions	☐	☐	☐	☐
Keeping appointments, taking medications and performing other medical treatments	☐	☐	☐	☐
If yes to any of these questions, who helps with these activities?				

Mood Screening: Requires Updating Annually for age 11 and up	
A person's mood can have a strong influence on their health status and overall wellbeing. Over the past 2 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

Social History: Requires Updating Annually

Please circle appropriate answers below and provide explanations where appropriate

Job concerns: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting ☐ Transportation

How stressful would you rate your job situation: (Circle number)

Not Very Stressful 0 1 2 3 4 5 6 7 8 9 10 Very Stressful

Have you had change in Marital Status: ☐ No ☐ Yes If yes, describe below:

How stressful would you rate your current living situation?

Not Very Stressful 0 1 2 3 4 5 6 7 8 9 10 Very Stressful

Do you fear for your safety in your current living situation? ☐ No ☐ Yes If yes, describe below:

Are there financial concerns that affect your ability: 1) to go to the doctor ☐ No ☐ Yes If yes, describe:
2) to obtain food and shelter ☐ No ☐ Yes If yes, describe:

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?
☐ No ☐ Yes If yes, describe:

Patient Signature:_____ Date:_____

Provider reviewed:_____ Date:_____