

INDIANA INTERNAL MEDICINE CONSULTANTS, P.C., HEALTH QUESTIONNAIRE

Name: _____

DOB: _____

Date: _____

Reason for visit and symptoms: _____

HEALTH HISTORY:

Are you being treated for or have you ever had any of the following health conditions?
Please check (✓). Space provided below for details or other health conditions not listed.

Allergies	Colitis	Defibrillator	Nervous system disease
Alcohol problems	Constipation	Failure	Osteoporosis/osteopenia
Anemia	COPD	Pacemaker	Obesity
Aneurysm	Dementia	Palpitations	Peptic ulcer(s)
Anxiety	Depression	Stents	Peripheral vascular disease
Arthritis:	Diabetes	Valvular disease	Pleurisy
<i>Osteoarthritis</i>	Last: HgA1 C# _____	Hemorrhoids	Pneumonia
<i>Degenerative</i>	Dilated eye exam _____	Hepatitis A B C other _____	Prostate problems
<i>Psoriatic</i>	Urine for microalbumin _____	High blood pressure	Seizure disorder
<i>Rheumatoid</i>	Diarrhea	HIV/AIDS	Sexually transmitted disease(s)
Asthma	Diverticulosis/diverticulitis	Hyperthyroidism	Sleep apnea
Atrial fibrillation	Eating disorder	Hypothyroidism	Stroke
Bleeding problem	Emphysema	Irritable bowel	TIA
Blood clots	Fertility issues	Kidney disease	Tremors
Blood transfusion	GERD	Kidney failure	Tuberculosis
Bronchitis	Glaucoma	Kidney stones	Urinary:
Cancer	Goiter	Low back pain	<i>Frequency</i>
Type _____	Gout	Lupus (SLE)	<i>Incontinence</i>
CHF	Headaches	Mental illness/mood disorder	<i>Infection(s)</i>
<input type="checkbox"/> systolic <input type="checkbox"/> diastolic	Heart	MRSA infection(s)	<i>Retention</i>
Ejection fraction _____	<i>Arrhythmia</i>	Narcolepsy	Varicose veins
Crohn's disease	<i>CAD (MI)</i>	Neuropathy	Weight problems

Other: _____

FAMILY HISTORY

Follow the lines across the page & mark appropriate box.

	Alive & well	Deceased	Age at Death	Cause of Death	High blood pressure	Heart disease	High cholesterol	Diabetes	Cancer	Asthma/lung disease	Tuberculosis	Arthritis	Kidney disease	Glaucoma	Stroke	Migraine	Mental illness	Alcoholism	Bleeds easily	Anemia	Gout	Seizures	Other
FATHER																							
GF <input type="checkbox"/> GM <input type="checkbox"/>																							
MOTHER																							
GF <input type="checkbox"/> GM <input type="checkbox"/>																							
BRO <input type="checkbox"/> SIS <input type="checkbox"/>																							
BRO <input type="checkbox"/> SIS <input type="checkbox"/>																							
BRO <input type="checkbox"/> SIS <input type="checkbox"/>																							
BRO <input type="checkbox"/> SIS <input type="checkbox"/>																							
SPOUSE																							

PSYCHOSOCIAL HISTORY:

Caffeine? Y/N Amount: _____ per day	Relationship status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Partnered
Tobacco? Y/N Amount: _____ per day	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Other
Type of tobacco _____ Quit yrs _____	How do you identify your sexual orientation?
Alcohol? Y/N Amount _____ Frequency _____	<input type="checkbox"/> Heterosexual (opposite sex partner) <input type="checkbox"/> Gay/lesbian (same sex partner)
Do you/or have you had a problem with drug use? Y/N: _____	<input type="checkbox"/> Transgender (how do you want to be addressed? _____)
Do you exercise? Y/N Hours _____ per week	<input type="checkbox"/> Bisexual
Children? Y/N Seatbelt usage _____ % of time worn	Have you had intercourse (oral, vaginal or rectal penetration) with a
Have you been hit or threatened in the past year? Y/N _____	male? Y/N _____ female? Y/N _____

PSYCHOSOCIAL HISTORY continued

Employment History:

Are there any cultural or religious beliefs that need to be considered in your care? Y/N If yes, explain _____

Potential barrier to learning: none inability to understand English language if other than English _____

blind poor vision deaf decreased hearing unable to talk unable to read memory loss

Learns best by: reading verbal instruction practicing talking watching Other _____

Do you have a Durable Power of Attorney? Y/N _____

(list person(s)) Healthcare representative? Y/N _____

Yes No Out of hospital Do Not Resuscitate (DNR)

Yes No Did you bring copies of above documents with you today?

Would you like information on any of the above? Y/N _____

Other: _____

List surgical procedures and reasons for hospitalizations including the year:

DRUG ALLERGIES:

MEDICATIONS:	NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN	
List all prescription medications you are now taking	(1)			(9)			
	(2)			(10)			
	(3)			(11)			
	(4)			(12)			
	(5)			(13)			
	*Additional space available on page 3 for medications and supplements	(6)			(14)		
		(7)			(15)		
		(8)			(16)		
SUPPLEMENTS:	NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN	
List all vitamins, hormones, alternative remedies or any over the counter medications you use	(1)			(5)			
	(2)			(6)			
	(3)			(7)			
	(4)			(8)			

REVIEW OF SYSTEMS Please check all positives

GENERAL	RESPIRATORY	GASTROINTESTINAL	MUSCULOSKELETAL
Fatigue/weakness	Allergies	High blood pressure	Hernia
Muscle weakness	Sore throat	Low blood pressure	Urinary frequency
Change in appetite: loss __ gain __	Hoarseness	Swollen leg(s)	Incontinence
Weight: loss __ gain __	Trouble chewing	Pain in legs when walking	Urgency
Fever/chills	Trouble swallowing	Varicose veins	Decreased flow
Night sweats	Cough	Phlebitis	Painful urination
Dizziness	Sputum production	Indigestion/heartburn	Hesitant flow
Blurred vision	Coughing blood	Choking	Nighttime urination: # of times __
Double vision	Wheezing	Nausea/vomiting	Blood in urine
Eye infections	Shortness of breath when lying flat	Vomiting blood	Discharge (urethral)
Eye pain	Shortness of breath at night	Change in bowel habits:	Joint pain (s)
Ringing in the ears/tinnitus	Decreased exercise tolerance	Diarrhea __ Constipation __	Muscle pain(s)
Ear infections	Unusual environmental exposures	Bloating/gassiness	Joint injury
Hearing loss	Chest pain	Frequency of BM ____	Joint swelling
Ear pain	Palpitations/irregular pulse	Black tarry stool	Bone pain
Bloody nose	Fainting	Bloody stool	Back pain
Congestion	Rheumatic heart disease	Hemorrhoids	
Nasal drainage	Murmur	Abd. pain: Location ____	
		Jaundice	

