Meetinghouse Family Physicians

COMPREHENSIVE HEALTH ASSESSMENT QUESTIONNAIRE

Our goal is to be your "Coordinator of Care" and to provide comprehensive care, physically, mentally and emotionally. This is an extensive questionnaire used to determine your treatment plan. Please take time to fill it out to the best of your ability.
Thank You

Patient Name_____ **DOB**_____ **Today's Date** _____
Emergency Contact: _____ **Relationship:** _____
Phone Number: _____

Medication Name & Dosages: (Please include over-the-counter medications, vitamins and all supplements')

_____
_____
_____
_____
_____

Allergies: (Medications, environmental, food , animal or plants)

_____
_____
_____

Personal and Family History: For each bodily system, please indicate whether you have had any of the symptoms or conditions.

Symptom / Condition	Self	Comments/ Explanation
Constitutional:		
Fever		
Night Sweats		
Weight Gain- how much weight & over what length of time?		
Weight loss- how much weight & over what length of time?		
Frequent or Chronic Sinus problem		
Visual Changes		
Other:		

Respiratory System	***Self***	***Comments/Explanation***
Emphysema / Chronic Bronchitis		
Pneumonia		
Snoring /Sleep Apnea		
Cough /Wheeze /Shortness of Breath		
Other		
Cardiac Systems/Risk Factors		
Chest Pain /Angina		
Heart Attack		
Stroke		
Coronary Artery Disease		
High Cholesterol		
Edema (swelling of the legs)		
Arrhythmia		
Hypertension (high Blood Pressure)		
Peripheral Vascular Disease		
Chronic or End Stage Kidney Disease		
Diabetes		
Other		
Gastrointestinal System		
Abdominal Pain		
Change in Bowel Habits		
Nausea / Vomiting		
Loss of Appetite		
Irritable bowel Syndrome		
Liver Disease- Hepatitis, Cirrhosis, Fatty Liver		
Hemorrhoids		
Diverticulosis or Diverticulitis		
Colon Polyps		
Gallbladder Disease		
Ulcers- please indicate location		
Other		
Reproductive System		
Abnormal Pap		
Fibroids		
Vaginal Discharge or Dryness		
Breast Pain /Mass/ Cyst		
Other		
Integumentary (Skin) System		
Skin Changes – Moles/ lesions		
Hair Changes- Thinning/Loss/growth		
Eczema		
Psoriasis		
Dry Skin		
Rash		
Other		
Psychiatric System		
Sleep Problems-Falling Asleep, Stay Asleep		
Anxiety/Depression		
Bipolar/Schizophrenia		
Other		

Neurological System	***Self***	***Comment/Explanation***
Frequent Falls		
Headache Migraine		
Memory Loss- Alzheimer's, Dementia, etc.		
Seizures/Epilepsy		
Other		
Metabolic / Endocrine System		
Thyroid Disorder- Hyper or Hypo		
Diabetes- What type		
Other		
Musculoskeletal System		
Joint Pain		
Muscle Weakness		
Swelling		
Arthritis		
Gout		
Chronic Pain		
Fractures- please indicate where		
Other		
Blood or Bleeding Disorder		
Anemia		
Blood clot		
Blood Transfusion		
Other		
General		
Cancer- type?		
Alcohol/ Drug Abuse		
Tobacco User		
Allergies- Seasonal or environmental		
Other		

Immunizations: Please indicate the year in which you received the vaccine.

Vaccine	**Received**	**Date**
Tetanus (Td)		
Tetanus with Pertussis (tdap)		
HPV		
Influenza		
Pneumovax		
Zostavax (Shingles)		

Screen Testing: Please indicate the year in which you completed each test.

Test	***Received***	***Date***
Colonoscopy		
Mammogram		
Pap Smear		
Bone Density		

Family History										
	Father	Mother	Grandmother	Grandfather	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased (List age)										
Diabetes										
Chronic Lung Disease										
Hypertension										
Heart Disease										
Stroke										
Kidney Disease										
Obesity										
Genetic Disorder										
Alcoholism										
Liver Disease										
Depression or Bipolar Disorder										
Colon or Rectal Cancer										
Breast Cancer										
Other Cancer										
Drug Abuse										
Other										

General Information:

Within the past twelve months have you been in the hospital? Yes No
If yes, please explain: _____

Within the past twelve months, have you seen any other physician? Yes No
If yes, please explain: _____

Do you have a "Living Will"? Yes No

Do you have a "Power of Attorney"? Yes No

Does *Meetinghouse Family Physicians'* have copies of the above to documents? Yes No

Alcohol/ Caffeine Use:

Do you drink caffeine? Yes No

Do you drink alcohol? Yes No

Number of drinks per week of alcohol? _____

Type of Alcohol? Beer Wine Liquor

Number of caffeine drinks per week? _____

Type of caffeine: Coffee Tea Soda Energy Drink

Tobacco/ Drug Use

Smoke Cigarettes: Never Formerly Yes

Quit Date: _____ How many years did you smoke? _____

How many cigarettes did you smoke? _____

Current Smoker: Cigarettes per day _____ Number of years _____

Do you currently use Electronic Cigarettes or Vape? _____

Have you ever chewed tobacco? Yes No

Have you had exposure to second hand smoke? Yes No

Do you use street drugs? Yes No

Type: Marijuana Cocaine Heroin Amphetamines

Other: _____

List any handicaps: _____

Do you wear a seat belt? Yes No

Do you exercise regularly? Yes No Amount /Type _____

Are there guns in your home? Yes No Locked Yes No

Highest level of Education _____

Can you read? Yes No

Preferred Language: _____

Can you write? Yes No

Occupation: _____

When was your last vacation? _____

Are there any barriers keeping you from achieving your medical goals? (Transportation, complexity of care, cost of medication, amount of medication prescribed or any other barriers) _____

_____

_____

Thank you for taking your time to fill out this form.