Health Care Consumer Questionnaire Patient DOB Date

Patient Name		**Date**	
DOB **Gender** ❑Female ❑Male		**SSN**	
Patient Address	**Phone**	**Emergency Contact**	**Phone**
	H **W** **C**		**H** **W** **C**
Primary Insurance	**Phone**	**Secondary Insurance**	**Phone**
Policy #		Policy #	

List ALL Health Care Providers from whom you are currently receiving care (or have seen within the past 12 months)**, AND ALL Health Care Providers from whom you are obtaining prescriptions.**

Health Care Provider	Phone	Health Care Provider	Phone

Have you completed Advance Health Care Directives? ❑Yes ❑No Please provide a copy as soon as possible *(Living Will or Durable Power of Attorney for Healthcare)*

If yes, please provide the name and contact information for your Health Care Power of Attorney

If No, whom would you prefer as a surrogate decision maker should you need one?

Do you have any religious or cultural beliefs that may affect your healthcare? If yes, explain

Describe the means by which you prefer to learn new information

❑Verbal Instruction ❑Written Instruction ❑Handouts ❑Visual (Pictures, Videos, etc)

Language you prefer to converse in

Level of education completed

❑<6th grade ❑6th – 8th grade ❑9th grade ❑12th grade ❑1-4 years college ❑>4 years college

If the person completing this form is not the patient, please write your full name, relationship to the patient, and the specific reasons that the patient is unable to complete this form.

 ❑The information on this page was reviewed with the patient **HCC** Initials _____ **HCP** Initials _____

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Allergies Please describe reactions

❑**Shellfish**
❑**IV Contrast**
❑**Penicillins**
❑**Other,** specify

Please list medications you are taking. Include ALL over the counter medications, herbs & vitamins.

Medication & Dose	Frequency	Medication & Dose	Frequency

Have you ever been exposed to known cancer-causing agents or inhalation hazards? ❑Yes ❑No
If yes, please list the agents as specifically as possible, and state the duration of exposure as best as possible.

Agent	Duration	Agent	Duration

Please list and describe your hobbies

Have you traveled in the past 12 months? ❑Yes ❑No If yes, please list locations and time spent traveling.

Within the United States	Duration	Outside the United States	Duration

Do you exercise? ❑Yes ❑No If yes, please describe activities, frequency and duration of each activity

Activity & Duration	Times/Week	Activity & Duration	Times/Week

 ❑The information on this page was reviewed with the patient **HCC** Initials _____ **HCP** Initials _____

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Substance Use and Personal Risk History		
Have you ever smoked tobacco as cigarettes, cigars or pipes?	❑Yes ❑No	#Packs #Years
Have you quit? If yes, when	❑Yes ❑No	
Have you ever chewed tobacco?	❑Yes ❑No	#Pouches #Years
Have you quit? If yes, when	❑Yes ❑No	
Have you considered quitting?	❑Yes ❑No	
Have you tried quitting? If yes, for how long did you quit?	❑Yes ❑No	
Do you drink alcohol?	❑Yes ❑No	#Drinks ❑Day ❑Week
1 "drink" is equal to 12 oz. beer,1.5 oz. 80-proof liquor, or 5 oz. glass of wine		
Have you ever lost consciousness as a result of drinking alcohol?		❑Yes ❑No
Have you ever had a "drink" to prevent tremors, sweats, or irritability?		❑Yes ❑No
Have you ever been ticketed or arrested for a DUI?		❑Yes ❑No
Have you been involved in a motor vehicle accident in the past 12 months?		❑Yes ❑No
Have you ever used drugs for recreational purposes?	❑Yes ❑No	Check all that apply
❑Amphetamines ❑Cocaine ❑Heroin ❑Inhalants ❑LSD ❑Marijuana ❑PCP ❑Other, specify		
Method of drug delivery you used ❑Ingestion ❑Injection ❑Inhalation		
How much of each drug would you use? *List drugs below*	**Amount**	**Frequency**
		❑Day ❑Week
		❑Day ❑Week
		❑Day ❑Week
		Check all that apply
Have you ever been dependent on prescription drugs?	❑Yes ❑No	❑Narcotics ❑Benzodiazepines
		Specify If Other
Are you sexually active?	❑Yes ❑No	
If yes, do you use contraception of any kind? **Check all that apply** ❑Condoms ❑Diaphragm ❑Intrauterine Device IUD ❑Pills, Implants, Patches		
How many sexual partners have you had in the past 12 months?		#
Do you feel safe in your relationship?		❑Yes ❑No
Have you ever been in a relationship where you were threatened, hurt or afraid?		❑Yes ❑No
Do you have a safe place to go, and do you have the resources to leave, if you feel threatened?		❑Yes ❑No
Have you ever had sex with a person who is the same gender as yourself, bisexual, or anyone who performs sexual favors in exchange for money or drugs?		❑Yes ❑No
Have you ever been diagnosed with a sexually transmitted disease (such as syphilis, HIV, herpes, gonorrhea, chlamydia or genital warts)?		❑Yes ❑No
Do you have any tattoos or body piercings?		❑Yes ❑No
Have you ever received transfusions of blood or blood products?		❑Yes ❑No
Describe your seatbelt use whether you are driving or are a passenger in a vehicle. ❑All the time ❑Most of the time ❑About half the time ❑Rarely ❑Never		
Do you keep firearms in your residence?		❑Yes ❑No
If yes, are they kept in locked compartments, or do they have safety locks on when not in use?		❑Yes ❑No
Can you perform your own hygiene, dressing, cooking and shopping needs?		❑Yes ❑No

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Prior Diagnostic Exam History Have you ever had the following exams? If so, list where and when.		
Exam		Location and Month/Year
PAP Smear	❑Yes ❑No	
Prostate Biopsy	❑Yes ❑No	
Mammogram	❑Yes ❑No	
Colonoscopy	❑Yes ❑No	
EGD (Esophageal endoscopy)	❑Yes ❑No	
EKG	❑Yes ❑No	
Cardiac Stress Test	❑Yes ❑No	
ECHO (Echocardiogram)	❑Yes ❑No	
Chest X-ray	❑Yes ❑No	
CT "Cat" Scan of Chest	❑Yes ❑No	
Pulmonary Function Test	❑Yes ❑No	
EEG (Electroencephalography)	❑Yes ❑No	
Bone Density Test	❑Yes ❑No	
Vaccinations Have you had any of the following vaccines? Check all that apply, and state date last received.		
Vaccine		Date Received
Influenza	❑Yes ❑No	
Pneumonia	❑Yes ❑No	
Tetanus	❑Yes ❑No	
BCG	❑Yes ❑No	
Varicella	❑Yes ❑No	
Human Papilloma Virus (Gardasil)	❑Yes ❑No	
Gynecologic History This section to be completed by females. Males should skip to next section.		
Have you ever been pregnant?	❑Yes ❑No	#Live births #Miscarriages or Abortions
How old were you when you started menstruating?		
How old were you when you started menopause?		
Have you ever used birth control pills, patches or implants?		❑Yes ❑No If yes, when
Have you ever taken hormone replacement therapy?		❑Yes ❑No If yes, when
Have you ever had an intrauterine (IUD) device?		❑Yes ❑No If yes, when
If you had an IUD placed, was it removed?		❑Yes ❑No If yes, when
Have you had a tubal ligation?		❑Yes ❑No If yes, when
Have you had your ovaries surgically removed?		❑Yes ❑No If yes, when

Surgical History Please list all surgical procedures you have had. Include physician's name, and date of procedure.

Surgical Procedure	Physician	Date

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Past Medical History Check "yes" or "no" for each problem listed.			
Adrenal Dysfunction	❑Yes ❑No	**Irregular Heart Rhythm**	❑Yes ❑No
Alzheimer	❑Yes ❑No	**Kyphosis**	❑Yes ❑No
Amyotrophic Lateral Sclerosis	❑Yes ❑No	**Liver Dysfunction**	❑Yes ❑No
Anorexia or Bulimia	❑Yes ❑No	**Kidney Failure, or Dysfunction**	❑Yes ❑No
Anxiety Disorder	❑Yes ❑No	**Malignancy** If yes, describe below	❑Yes ❑No
Arteriovenous Malformations (AVMs)	❑Yes ❑No		
Arthritis	❑Yes ❑No		
Asthma	❑Yes ❑No	**Mania**	❑Yes ❑No
Autoimmune Disease	❑Yes ❑No	**Muscular Dystrophy**	❑Yes ❑No
Bipolar Disorder	❑Yes ❑No	**Myocardial Infarction (Heart Attack)**	❑Yes ❑No
Bleeding Disorder	❑Yes ❑No	**Narcolepsy**	❑Yes ❑No
Cataracts	❑Yes ❑No	**Obstructive Sleep Apnea**	❑Yes ❑No
Cerebrovascular Accident (Stroke)	❑Yes ❑No	**Organ Transplant** If yes, describe	❑Yes ❑No
Chemotherapy If yes, state when	❑Yes ❑No		
		Osteoporosis	❑Yes ❑No
Claudication	❑Yes ❑No	**Pancreatitis**	❑Yes ❑No
Clotting Disorder	❑Yes ❑No	**Periodic Limb Movement Disorder**	❑Yes ❑No
Congenital Heart Defects	❑Yes ❑No	**Peripheral Artery Disease**	❑Yes ❑No
Coronary Artery Disease	❑Yes ❑No	**Personality Disorder**	❑Yes ❑No
COPD	❑Yes ❑No	**Pituitary Dysfunction**	❑Yes ❑No
Cystic Fibrosis	❑Yes ❑No	**Polycystic Ovarian Syndrome**	❑Yes ❑No
Depression	❑Yes ❑No	**Pulmonary Artery Hypertension**	❑Yes ❑No
Diabetes	❑Yes ❑No	**Pulmonary fibrosis**	❑Yes ❑No
Dialysis	❑Yes ❑No	**Radiation Therapy** If yes, explain	❑Yes ❑No
Eclampsia or Pre-eclampsia	❑Yes ❑No		
Endocarditis	❑Yes ❑No	**Recurrent Infections**	❑Yes ❑No
Endometriosis	❑Yes ❑No	**Restless Leg Syndrome**	❑Yes ❑No
End Stage Renal Disease	❑Yes ❑No	**Sarcoidosis**	❑Yes ❑No
Erectile Dysfunction	❑Yes ❑No	**Schizophrenia**	❑Yes ❑No
Esophageal Dysfunction	❑Yes ❑No	**Scleroderma**	❑Yes ❑No
Fibromyalgia	❑Yes ❑No	**Scoliosis**	❑Yes ❑No
Gallstones	❑Yes ❑No	**Seizure Disorder**	❑Yes ❑No
Gastritis or Gastric Ulcers	❑Yes ❑No	**Sickle Cell**	❑Yes ❑No
GERD (reflux problems)	❑Yes ❑No	**Sjogren**	❑Yes ❑No
Glaucoma	❑Yes ❑No	**Skin Disorders (Psoriasis, Acne)**	❑Yes ❑No
Heart or Valve Defects	❑Yes ❑No	**Thalassemia**	❑Yes ❑No
Hemochromatosis	❑Yes ❑No	**Thrombocytopenia**	❑Yes ❑No
Hemorrhoids	❑Yes ❑No	**Thrombophilia**	❑Yes ❑No
Hepatitis	❑Yes ❑No	**Transfusions**	❑Yes ❑No
HIV or AIDS	❑Yes ❑No	**Tuberculosis**	❑Yes ❑No
Hypertension	❑Yes ❑No	If yes, have you been treated?	❑Yes ❑No
Hyperthyroidism	❑Yes ❑No	**Urinary retention or urgency**	❑Yes ❑No
Hypotension	❑Yes ❑No	**Vasculitis**	❑Yes ❑No
Hypothyroidism	❑Yes ❑No	**Visual defects**	❑Yes ❑No
Inflammatory Bowel Disease	❑Yes ❑No	**Vocal cord dysfunction/paralysis**	❑Yes ❑No

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Review of Systems			
In the last 6 months have you experienced the following symptoms. Check either "yes" or "no" for each symptom.			
Constitutional		**Genitourinary**	
Weight Loss or Gain	❑Yes ❑No	Blood in your urine	❑Yes ❑No
Appetite changes (increased or decreased)	❑Yes ❑No	Menstrual changes	❑Yes ❑No
Fatigue, profound and impairs daily function	❑Yes ❑No	Urinating that is painful or difficult	❑Yes ❑No
Fever	❑Yes ❑No	Erection problems	❑Yes ❑No
Shakes/sweats from lack of alcohol or drug	❑Yes ❑No	Vaginal discharge or bleeding	❑Yes ❑No
Eyes		**Musculoskeletal**	
Eye pain or drainage	❑Yes ❑No	Broken bones	❑Yes ❑No
Visual changes	❑Yes ❑No	Joint pain or swelling	❑Yes ❑No
Dry, irritated eyes	❑Yes ❑No	Muscle aches	❑Yes ❑No
ENT/Mouth		Muscle weakness	❑Yes ❑No
Ear pain or drainage	❑Yes ❑No	Back pain	❑Yes ❑No
Frequent sinus infections	❑Yes ❑No	**Skin/Breasts**	
Hearing changes or loss	❑Yes ❑No	Masses or lumps	❑Yes ❑No
Nosebleeds	❑Yes ❑No	Nipple discharge	❑Yes ❑No
Dizziness	❑Yes ❑No	Rashes or nonhealing ulcers	❑Yes ❑No
Respiratory		**Neurologic**	
Blood in your sputum	❑Yes ❑No	Seizures	❑Yes ❑No
Chest tightness	❑Yes ❑No	Coughing or choking with swallowing	❑Yes ❑No
Cough lasting >1 month, productive or not	❑Yes ❑No	Excessive daytime sleepiness	❑Yes ❑No
Shortness of breath	❑Yes ❑No	Extremity pain or burning sensations	❑Yes ❑No
Wheezing	❑Yes ❑No	Hallucinations	❑Yes ❑No
Chest pain with inhalation or coughing	❑Yes ❑No	Numbness or tingling	❑Yes ❑No
Cardiovascular		Difficulty falling asleep, staying asleep	❑Yes ❑No
Chest pain or heaviness	❑Yes ❑No	**Endocrinologic**	
Palpitations	❑Yes ❑No	Hair loss	❑Yes ❑No
Fainting or near fainting spells	❑Yes ❑No	Frequent urination	❑Yes ❑No
Swelling of feet or legs	❑Yes ❑No	Increased thirst	❑Yes ❑No
Shortness of breath lying flat in bed	❑Yes ❑No	Heat or cold intolerance	❑Yes ❑No
Gastrointestinal		**Heme/Lymph**	
Abdominal pain	❑Yes ❑No	Bleeding from gums or nose	❑Yes ❑No
Blood in your stool	❑Yes ❑No	Unexplained bruising	❑Yes ❑No
Constipation	❑Yes ❑No	Night Sweats	❑Yes ❑No
Diarrhea or Food Intolerance	❑Yes ❑No	Swollen, painful lymph nodes	❑Yes ❑No
Heartburn or Indigestion	❑Yes ❑No	**Allergy/Immun**	
Vomiting or nausea lasting for >1 day	❑Yes ❑No	Watery eyes	❑Yes ❑No
Swallowing difficulty	❑Yes ❑No	Runny nose	❑Yes ❑No
Psych		Food intolerance	❑Yes ❑No
Anxiety without clear explanation	❑Yes ❑No	Frequent skin sores	❑Yes ❑No
Sadness lasting for days or weeks	❑Yes ❑No		
Hearing voices	❑Yes ❑No		
Thoughts of hurting yourself	❑Yes ❑No		
Thought of hurting others	❑Yes ❑No		
Fear of people, places or things	❑Yes ❑No		

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Family Medical History Please list all known medical problems in your family.

(Specify M=Mother, F=Father, B=Brother, S=Sister, So=Son, D=Daughter, GM=Grandmother, GF=Grandfather)

Medical Problem	Relative	Medical Problem	Relative

Additional Information that you feel may be helpful for your health care provider to know.

Health Care Provider Notes

Referral Information – We would appreciate learning how you heard about us? Check one, please

- ❑Another physician, nurse practitioner or physician assistant?
  If so, please specify who:
- ❑Family member or friend who is a patient of this clinic
- ❑Family member or friend who is NOT a patient of this clinic
- ❑Sign outside your office
- ❑Billboard Ad
- ❑Media Ad *Please specify* ❑Television ❑Radio ❑Newspaper Ad
- ❑Hospital referral service
- ❑Phone book
- ❑Internet
- ❑Other, *please specify*