Greensboro Medical Associates, PA

HEALTH INFORMATION QUESTIONNAIRE

NAME ______________________________________ **AGE** _______ **D.O.B.** __________
LAST, FIRST MIDDLE

PLACE OF BIRTH ____________________ **PRIMARY CARE M.D.** __________________

OTHER DOCTORS YOU SEE ____

MARITAL STATUS (circle one) **Single Married Separated Divorced Widowed**

EMPLOYMENT STATUS Full-Time Part-Time Not Employed Retired Student

EMPLOYER ______________________________**OCCUPATION** _____________________

HOW WERE YOU REFERRED TO US ____

MAIN REASON FOR VISIT ____

EDUCATION (years) _____ **RELIGION** ____________ **MILITARY SERVICE** ____________

REGULAR EXERCISE (type) ______________ **(circle) none light moderate strenuous**

HOBBIES/SPORTS ____

SPECIAL DIET __YES __NO WHAT TYPE? _____________________________

HABITS-- Have you used IV drugs?___ marijuana?___ narcotics?___ etc.?_______

Tobacco-- Type?________________ How much?___________ Quit?__________

Caffeine—(cups per day) Coffee:_______ Tea:_______ Cola:________

Alcohol-- Type?__________ How much?_________ Days per week______Quit?__________

History of Blood Transfusions Yes No AIDS Blood Test Yes No

Sexual Orientation (circle) Heterosexual Homosexual Other

MEDICATIONS (List all medications, eye drops, vitamins, including over-the-counter medications and supplements – include dose and frequency)

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

DRUG OR FOOD Allergies + Reaction :____

PREVIOUS SURGERIES ____

PREVIOUS INJURIES ____

PREVIOUS HOSPITAL STAYS ____

IN CASE OF EMERGENCY, CONTACT :____

ADDRESS (of above) ____

PHONE (of above) **home**________________ **cell**____________________ **work**__________________

Living Will? Yes No DNR ORDER? Yes No Advance Directives? Yes No

FAMILY MEDICAL HISTORY

RELATIVE	AGE	MEDICAL CONDITIONS	AGE and CAUSE OF DEATH
Mother			
Father			
Sisters			
Brothers			
Daughters			
Sons			

Any other medical conditions, such as diabetes, cancer, melanoma, aneurysm, heart disease or stroke in relatives?____

YOUR HEALTH (please circle):

Your general health:	Good	Fair	Poor
Your sleep quality:	Good	Fair	Poor
Your energy level:	Good	Fair	Poor

Have you had? (Please circle current symptoms and underline past symptoms)

change in weight
faints
night sweats
fatigue
hot or cold tendency
poor appetite
increased thirst
depression
anxiety
mood swings
psychiatric treatment
memory loss
seizures
fainting spells
headaches
numbness/tingling
tremors “shakes”
lumps or bumps
skin changes
easy bruising/bleeding
change in vision
hearing change
ringing in ears
balance problem
dry eyes or mouth
room spinning
nose/sinus problems

hay fever
sore throat
hoarseness
loss of taste
wheezing
coughing
coughing up blood
shortness of breath
………at rest
………on exertion
………lying flat
………sudden awakening
chest pain/tightness
palpitations
leg cramps
swollen feet/ankles
cold or blue hands or feet
varicose veins
phlebitis
heartburn/indigestion
trouble swallowing
nausea
vomiting
diarrhea
constipation
vomiting blood
blood in stool

black stools
jaundice (yellow skin)
abdominal pain
hemorrhoids
change in bowel habits
kidney stones
change in urination
burning, discharge
prostate trouble
sexual difficulties
aching muscles/joints
back pain
neck pain
swollen joints
treatment for
alcohol/drugs
radiation treatment
cancer

FEMALE
abnormal vaginal blood
birth control
pain with intercourse
previous pregnancies
abnormal pap smear
breast lumps
breast discharge

Last Colonoscopy __________________
Last Mammogram __________________
Last Eye Exam _____________________
Last Pap Smear ____________________
Last Bone Density __________________

Last Tetanus Vaccine _________________
Last Pneumonia Vaccine ______________
Last Aortic Aneurysm Screen __________
Last Hepatitis B Vaccine _______________

I certify that the information I have given above is correct to the best of my knowledge.

____ __________ ____________________________
Patient’s Signature Date mobile #

____ _________________
Signature and relationship of person filling out form Date