MERIDIAN PRIMARY CARE *PATIENT HEALTH QUESTIONNAIRE*

NAME:_____DATE OF BIRTH:_____DATE:_____

List PRIOR PRIMARY CARE physicians:_____

List **SPECIALISTS** HAVE SEEN FOR ANY MEDICAL REASON: _____

Past Medical and Family History

HAVE YOU OR ANY FAMILY MEMBER EVER HAD:	**YOU**	**or list FAMILY MEMBER(S)**
Diabetes or "Borderline diabetes" (**CIRCLE** which or both)	____	_____
High Blood pressure	____	_____
Stroke or "Mini strokes"/TIA (**CIRCLE** which or both)	____	_____
Heart attack	____	_____
Asthma	____	_____
COPD or Emphysema	____	_____
High Cholesterol	____	_____
Hyperthyroid or Hypothyroid (**CIRCLE** which or both)	____	_____
"Passing out"/ blackouts / fainting	____	_____
Depression	____	_____
Anxiety	____	_____
Other mental diagnoses: _____	____	_____
Seasonal or Environmental Allergies	____	_____
Acid reflux / GERD	____	_____
Heart murmur or "extra heart noise"	____	_____
Irregular heart rhythm or "extra heart beats"	____	_____
Family members with sudden death at young age?	____	_____
Physical or emotional abuse?	____	_____
Glaucoma (**Which**? "narrow angle" or "wide angle")	____	_____
Bleeding disorders / Blood diseases: _____	____	_____
Drug abuse ("street" or prescription)	____	_____
Hepatitis or HIV (CIRCLE which or both)	____	_____
Alcoholism	____	_____
Colon polyps	____	_____
Aneurysms (Where in body?_____)	____	_____

YOUR OTHER MEDICAL ISSUES :_____

_____

CANCERS: *Please list **family members** and their **AGE** at diagnosis if they have had any of the following:*

BREAST CANCER_____ PROSTATE CANCER_____

COLON CANCER_____ LUNG CANCER_____

OVARIAN CANCER_____UTERINE CANCER_____

OTHER CANCERS:_____

Have you had **SURGERY** or been **HOSPITALIZED** for any reason?:_____

_____

MEDICATION **ALLERGIES** or SENSITIVITIES and **your REACTION** to the medication:

_____

_____

***NAME:*_____*DATE OF BIRTH:*_____**

Please list any prescription medications, birth control, vitamins, or supplements you take:

MEDICATION	DOSE /FREQUENCY	HOW LONG TAKING?	WHO IS PRESCRIBING	REASON FOR MED

Social History

Do you SMOKE or CHEW TOBACCO? _____ Yes ____ No If yes, # PACKS PER DAY:_____ for _____YEARS

If CURRENTLY SMOKING, what have you used to try to quit? _____

If an EX-SMOKER / CHEWER & WHEN did you QUIT? _____ How did you quit? _____

How many packs per day did you use before? _____ for ____ YEARS;

How much ALCOHOL do you drink? List the AMOUNT and TYPE per DAY: _____

How much CAFFEINE per day? List AMOUNT and TYPE per DAY: _____

Do you use any "STREET DRUGS?" _____ YES _____ NO TYPE: _____

Have you ever had an issue OVERUSING PRESCRIPTION drugs? _____

Do you EXERCISE? _____ Rarely _____ 1 – 2 times/wk _____3 – 4 times/wk _____ >4 times/wk

Do you have a LIVING WILL _____ Yes _____No A MEDICAL POWER of ATTORNEY? ____ Yes ____ No

Ever had a blood transfusion? _____Yes_____No

Any TATTOOS or PIERCINGS not done with sterile equipment? Y / N Do you go TANNING? Y / N

Have you ever had a Sexual Transmitted Disease (STD)? ____Yes (type:_____) or _____No

FEMALES ONLY

Do you do self breast exams? Y / N When was your last MAMMOGRAM (x-ray of your breasts)?_____

When was your last GYNECOLOGICAL exam (PAP smear, breast exam, and bimanual exam)? _____

Age your menstruation /periods started: _____ FREQUENCY: _____ Regular or _____ Irregular

FLOW: ____ Heavy or ____ Moderate or ____ Light # Days your periods last? _____

Pain / cramps with flow? ___ Yes or ___ No Age at MENOPAUSE: _____hysterectomy?_____

Pregnancies: ____ # Living children:____ Currently PREGNANT? Y / N Currently BREAST FEEDING? Y / N

MALES ONLY

Do you do self testicular exams? Y / N History of Erectile Dysfunction? Y / N Any penile discharge? Y / N

Have you ever had a RECTAL or PROSTATE exam? ____Yes (When? _____) or ____No

Have you ever had a Prostate blood test, called a "PSA"? _____ Yes _____ No

When was your last VACCINE for TETANUS?_____PNEUMONIA?_____FLU?_____OTHER? _____

Had CHICKEN POX? YES / NO When was your last EYE EXAM? _____Last DENTAL exam?_____

Last COLONOSCOPY? _____ BONE DENSITY SCAN?: _____

PATIENT SIGNATURE: _____DATE: _____