

Date:

JACKSONVILLE MEDICAL CARE HEALTH HISTORY- ADULT

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (<i>Last, First, M.I.</i>):	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status:	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Previous or referring doctor:	Date of last physical exam:	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

General	In general would you say your health is: Excellent, Very Good, Good , Fair or Poor		
	In general would you say your dental health is: Excellent, Very Good, Good , Fair or Poor		
	Please select your current pain level (0-No pain-10 in severe pain) 0 1 2 3 4 5 6 7 8 9 10		
ADL	Do you require help with any of the following activities? (please circle all that apply) Bathing, Dressing, Toilet Use, Transferring, Urine/Bowel Incontinence, Eating, Shopping, Housekeeping, Handling Finances, Taking Medications		
Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
Personal Safety	Do you live alone?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you wear your seatbelt?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have throw rugs in your home?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does your home have poor lighting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have a slip resistant mat in Bathtub and/or shower?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have grab bars in your bathroom?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have functioning smoke alarms in your home?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have handrails on stairs and steps at your home?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have frequent falls?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have vision or hearing loss?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?		<input type="checkbox"/> Yes <input type="checkbox"/> No

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Allergies to medications

Name the Drug	Reaction You Had

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

List any medical problems that other doctors have diagnosed

Do you currently have?

Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Defibrillator <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Stimulator <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Pump <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergy to IV Contrast <input type="checkbox"/> Yes <input type="checkbox"/> No
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Have you ever had a blood transfusion? Yes No

Childhood illness: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio

Other hospitalizations

Year	Reason	Hospital

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Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia	
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox	
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>	
	<input type="checkbox"/> Shingles	<input type="checkbox"/> Other:	
Preventative Screenings and dates:	<input type="checkbox"/> Aortic Ultrasound	<input type="checkbox"/> Dilated Eye Exam/Eye Exam	<input type="checkbox"/> Other:
	<input type="checkbox"/> Bone Density Test	<input type="checkbox"/> Mammogram	
	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Pap	
	<input type="checkbox"/> Dental Exam	<input type="checkbox"/> Prostate Screening (PSA)	

MENTAL HEALTH		
Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel anxious often?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you unable to control or stop worrying?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you often feel stress about your health, finances, family, relationships or work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you get the social and emotional support you need?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

List any other doctors who follow your care and why they see you:

Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Surgeries		
Year	Reason	Hospital

FAMILY HEALTH HISTORY					
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
Mother				<input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

Tobacco	Do you use tobacco?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day		<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day	
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit				
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?					
	Have you ever felt you should cut down on how much you drink?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have people annoyed you by criticizing your drinking?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever felt bad about your drinking?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drugs	Do you currently use recreational or street drugs?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?				<input type="checkbox"/> Yes	<input type="checkbox"/> No

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WOMEN ONLY			
Age at onset of menstruation:			
Date of last menstruation:			
Period every ____ days			
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____			
Are you pregnant or breastfeeding?			
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?	<input type="checkbox"/>	Yes	<input type="checkbox"/> No
Date of last Mammogram?			

MEN ONLY		
Do you usually get up to urinate during the night?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
If yes, # of times ____	<input type="checkbox"/>	Yes <input type="checkbox"/> No
Do you feel pain or burning with urination?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/>	Yes <input type="checkbox"/> No
OTHER PROBLEMS	<input type="checkbox"/>	Yes <input type="checkbox"/> No

Sex	Are you sexually active?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

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CHECK IF YOU HAVE, OR HAVE HAD, ANY SYMPTOMS IN THE FOLLOWING AREAS TO A SIGNIFICANT DEGREE AND

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

LAB

LAST LAB (APPROXIMATE DATE):	ORDERED BY (WHOM):
WHAT LAB WAS DONE?	