PINEHURST PRIMARY CARE
HEALTH QUESTIONNAIRE

In order to make your first visit more personal yet comprehensive, please assist the physician in gathering the necessary information to aid in your health treatment plan. Filling this out thoughtfully ahead of time will limit delays in the waiting room.

NAME:_____ **DATE:**_____

AGE:_____ **DATE OF BIRTH:**_____

What is the purpose of this visit?

Is your health good in general? YES___ NO___
What are your major medical problems at present?

Are you being treated by another physician currently?
Who?

What medical conditions have you been treated for at anytime?

	Date of Onset		Date of Onset
1)	_____	4)	_____
2)	_____	5)	_____
3	_____	6)	_____

What surgeries have you had? Approximate dates.

	Approx. date
1_____	_____
2_____	_____
3_____	_____
4_____	_____

What prescription medicines are you taking? (PLEASE BRING BOTTLE)

What over-the-counter medicines, vitamins, and other products, do you use for your health?

List any allergic reactions you have had to medicine.

FAMILY HISTORY

Have any of your close relative had:(check any that apply)

Diabetes (High sugar) ____
High blood pressure___
Heart attacks___
Colon Cancer___
Breast Cancer___
Strokes___
Sickle cell disease___
Sudden unexplained death___
Drug or alcohol problems___
Osteoporosis___
Fractured hip___
Allergies___

List any family members who have died and why they died if known.

SOCIAL HISTORY:

Are you married, single, divorced, widowed?

Who lives with you in your house?

What type of work do you or did you do?

List any particular hobbies.

HABITS:

Do you wear seat belts all of the time? Yes___No___
Do you smoke cigarettes? Yes___ No___
If yes: how many packs a day?
how many years?
Have you ever quit smoking? Yes___No___ When?
Do you smoke a pipe or cigars? Yes___ No___

Do you use alcohol at present? Yes___ No___
If yes: how many drinks per week?
what time of the day?
what type of alcohol?
If no: have you ever drank? When?

Do you exercise regularly? Yes___ No___
Describe:

Are you at risk for AIDS? Yes___ No___
Do you use intravenous or street drugs? Yes___ No___
Do you handle blood or blood products? Yes___ No___
What type of diet do you maintain?

DISEASE PREVENTION:

List if you have had the following and when:

Tetanus vaccine _____
Pneumonia vaccine _____
Flu vaccine _____
Hepatitis B vaccine _____
Blood transfusion _____
HIV test _____
Tuberculosis skin test(PPD) _____
Mammogram _____
Any abnormal ones _____
Pap Smear _____
Any abnormal ones _____
Colon Cancer tests _____
What type and when? _____

Prostate Cancer tests _____
Cholesterol level _____

NAME:_____DATE_____

SYSTEMS REVIEW: Please indicate whether you have had significant problems with the following.

a. HEENT

Glaucoma Yes____No____
Poor Vision Yes____No____
Cataracts Yes____No____
Recurrent dizziness or light headedness Yes____No____
Poor Hearing Yes____No____
Ringing of ears Yes____No____
Hay Fever Yes____No____
Post Nasal Drip Yes____No____
Sinus Infections Yes____No____
Chronic Hoarseness (lasting several weeks) Yes____No____

b. RESPIRATORY/CARDIOVASCULAR

Asthma or recurrent wheezing Yes____No____
Chronic cough or emphysema Yes____No____
Tuberculosis Yes____No____
High blood pressure Yes____No____
Angina Yes____No____
Heart Attack Yes____No____
Chest pain, tightness, pressure or squeezing or burning in the chest during exertion or after meals Yes____No____
Palpitations or irregular heart beat Yes____No____
Difficulty breathing while active Yes____No____
Difficulty breathing while resting Yes____No____
Rheumatic fever or a heart murmur Yes____No____
Leg pain while resting or with exercise Yes____No____
Varicose veins or swelling in the legs or feet Yes____No____

c. GASTROINTESTINAL

Poor appetite Yes____No____
Excessive appetite Yes____No____
Weight gain or loss Yes____No____
Frequent indigestion Yes____No____
Frequent nausea or vomiting Yes____No____
Frequent heartburn Yes____No____
Difficulty swallowing Yes____No____
Severe pain in the abdomen Yes____No____

NAME_____DATE_____

GASTROINTESTINAL (Con't)

Stomach or duodenal ulcers Yes____No____
Regurgitation of food or acid after big meals when bending over or lying down Yes____No____
Vomiting blood Yes____No____
Had gallstones Yes____No____
Passed blood in the stool or black or tarry stools Yes____No____
Frequent stools Yes____No____
Chronic constipation Yes____No____
Have you had a colon polyp or colon cancer Yes____No____
Hemorrhoids Yes____No____
Jaundice, liver or gall bladder disease or hepatitis Yes____No____

d. GU

Kidney or bladder infections Yes____No____
Blood in the urine Yes____No____
Frequent, painful or difficulty urinating Yes____No____
Inability to control urine Yes____No____
History of kidney stones Yes____No____
Venereal disease Yes____No____
Difficulty with sexual functions Yes____No____
MEN: History of prostate trouble, difficulty starting stream or double voiding Yes____No____
WOMEN: Difficulty with periods: excessive flow, irregular or usually painful Yes____No____
Abnormal pap smear Yes____No____, date of last pap smear_____
If past menopausal, date of menopause:

Number of Pregnancies: Number of children:

e. MUSCULOSKELETAL

History of arthritis Yes____No____
Painful or swollen joints Yes____No____
History of back problems Yes____No____
History of back injury Yes____No____
Difficulty with pain or weakness in your muscles Yes____No____

NAME_____DATE_____

f. GENERAL

History of stroke or seizures Yes____No____
Do you have dizzy or fainting spells Yes____No____
Migraine headaches Yes____No____
Severe head injuries or knocked unconscious Yes____No____
Chronically tired or no energy Yes____No____
Do you have spells of depression Yes____No____
Do you have difficulty sleeping Yes____No____
Do you wake up fresh and rested most mornings Yes____No____
Do you have periods of days or weeks when you couldn't "GET GOING"
Yes____No____
Is anyone plotting against you Yes____No____
Does it seem nobody understands you Yes____No____
Even when you are with people, do you feel lonely much of the time
Yes____No____
Do you have crying spells Yes____No____
Have you ever sought or had psychiatric help Yes____No____
Do you have diabetes or an abnormal blood sugar Yes____No____
Do you have thyroid trouble Yes____No____
Do you have excessive thirst Yes____No____