



Original Date:

Date Revised:

## Health History Questionnaire

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

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

### PERSONAL HEALTH HISTORY

<b>Childhood Illnesses:</b>	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Polio
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**List any medical problems other doctors have diagnosed:**

**Surgeries:**

Year:	Reason:	Hospital:

**Other Hospitalizations:**

Year:	Reason:	Hospital:

Have you ever had a blood transfusion?  Yes  No

*Please turn to next page*

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name of drug	Strength	Frequency taken

Allergies to Medications	
Name of drug	Reaction you had

HEALTH HABITS AND PERSONAL SAFETY				
<b>Exercise</b>	<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/wk for 30 min)			
	<input type="checkbox"/> Regular vigorous exercise (i.e. work or recreation, 4x/wk for 30 min.)			
<b>Diet</b>	Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, are you on any physician prescribed medical dieting?			
	# of meals you eat in an average day?			
	Rank salt intake	<input type="checkbox"/> High	<input type="checkbox"/> Medium	<input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> High	<input type="checkbox"/> Medium	<input type="checkbox"/> Low
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	
	# of cups/cans per day			
<b>Alcohol</b>	Do you drink alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you are drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you considered stopping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you ever experienced blackouts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Are you prone to 'binge' drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you drive after drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Tobacco</b>	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			
# of years:		or year quit:		
<b>Drugs</b>	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	

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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 any 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		

<b>Men Only</b>		
Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, _____ # of times		
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?		

<b>Other Problems</b>		
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain		
<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	

<b>Sex</b>	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 contraceptives or barrier method used:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	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	<input type="checkbox"/> Yes	<input type="checkbox"/> No

	your provider about your risk for this illness?		
<b>Personal Safety</b>	Do you live alone?	<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
	Do you have an advanced 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
	Physical or mental abuse have also become a major public health issue 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

<b>Family Health History</b>						
Age		Significant Health Problems	Age		Significant Health Problems	
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F		
Mother				<input type="checkbox"/> M <input type="checkbox"/> F		
Siblings	<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>			



## AUTHORIZATION FOR TREATMENT & HEALTH CENTER SERVICES

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ MR#: \_\_\_\_\_

The Community Health Center of Cape Cod strives to be a comprehensive health center, responding to community health needs, supporting long-term healing, and empowering individuals to manage their own health. We are committed to providing high quality, comprehensive, integrated health care to all patients we serve. Health Center providers and staff will make recommendations regarding your care and treatment.

I hereby authorize medical and/or dental treatment by Community Health Center of Cape Cod. I understand that medical treatment and procedures are provided by independent practicing physicians, nurse practitioners, physician assistants, dentists, or dental hygienists.

I agree to give the Health Center accurate information regarding medical services, physicians and facilities who are providing my care.

I agree to participate in the decisions regarding my care and follow recommendations of Community Health Center of Cape Cod, as agreed.

I agree to inform Community Health Center of Cape Cod regarding any changes in health and/or reactions to treatment and medications, including pain.

I retain the right to seek treatment elsewhere at my own expense.

I agree to provide Community Health Center of Cape Cod with insurance or financial information as requested, and will notify the Health Center of any changes in my insurance and financial circumstances.

I understand that in order to provide quality services, it may be necessary for Community Health Center of Cape Cod to communicate with and/or refer to outside resources. Communication between me and Health Center staff is confidential and release of any medical information must have my written permission. There are, however, legal limitations to this confidentiality. I have received a copy of Community Health Center of Cape Cod's Privacy Practices and understand my right to confidentiality.

I understand that I am responsible for all my personal effects during a health center visit.

I agree to treat Community Health Center of Cape Cod personnel with respect.

I understand that if medications are given to me through Community Health Center of Cape Cod, that they are not in childproof containers, and I agree that the Health Center will not be responsible for the safe storage of my medications.

The services of Community Health Center of Cape Cod and its professional staff are available only during posted clinic hours. Please refer to Off-Hours Policy posted in waiting area and Patient Information Guide.

Community Health Center of Cape Cod provides primary care, behavioral health and general dentistry. The ability to provide additional evaluation, such as laboratory and x-ray studies and specialty referrals and treatment is limited. More extensive studies and professional care will be the responsibility of the patient. Every attempt will be made to provide assistance with arranging such service.

I understand that if I have any questions or concerns about this form or any Health Center services or policies, I may ask to meet with any staff member during health center hours.

I agree to notify the Health Center within 24 hours if I am unable to keep my appointment.

Signature of Patient — \_\_\_\_\_ Date \_\_\_\_\_

