Lifetime Health medical group

Risk Factor and Health History Questionnaire

Date:				
Name:		❑ M ❑ F	Birthdate:	Birthplace:
Address:		Marital Status:	Spouse Name:	
Home Phone:	Work Phone:	Other emergency contact (name and number):		
Occupation: (If retired, former)		Other family members in Group Health:		
Education: Highest grade completed: ❑ Elementary ❑ High school ❑ College ❑ Other _________				

Under age 65 patients:
Please indicate which date you have selected for a Health Assessment appointment (HAP): ________________________
(A Health Center Representative will contact you to confirm your selected day and schedule a time for your appointment. If you choose not to participate in HAP, please return your completed Health History Questionnaire so we can start a medical record for you.)

Over age 65 patients:
Your Health Assessment Appointment has been scheduled for you and can be found on the enclosed appointment card.
How would you rate your overall health and well being? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
What are your major health concerns? ____

Instructions - Please check YES or NO.

1. **SMOKING:**
   Have you ever smoked? .... ❑ Yes ❑ No
   No. of years smoking ________________ If you have quit, when ___________________
   Cigarettes, no. of packs per day _________ Cigars, no. per day _________ Pipe _________

2. **NUTRITION:**
   Please fill in your approximate: Height _________ Weight _________
   Do you eat regularly? ❑ Breakfast ❑ Lunch ❑ Dinner ❑ Snacks/fluid
   How many servings do you get from the four basic food groups daily:
   1. Dairy (milk, cheese, yogurt): ______ servings
   2. Fruits and vegetables: ______ servings
   3. Starches (bread, rice, pasta, etc.): ______ servings
   4. Protein (meat, fish, eggs, etc.): ______ servings
   Do you consider yourself?: ❑ Correct weight ❑ Overweight ❑ Underweight
   Do you drink caffeinated beverages? .... ❑ Yes ❑ No
   (i.e., coffee, tea, cola's other sodas) No. per day ___________
   Are you on a special diet? .... ❑ Yes ❑ No
   What do you restrict? ____
   Why? ____
   RD Comments: ____
   RD Signature: ....

3. **EXERCISE:**
   Do you exercise regularly? .... ❑ No ❑ Yes
   How often? ________ What type of exercise? _______________________________

4. **ALCOHOL/DRUGS:**
   How many alcohol based drinks do you usually have? (Include beer, wine, whiskey, gin, vodka):
   Per day: ______ Per week: ______
   Have drinking or drugs ever caused you a problem? (Health, legal, driving, family or work): .... ❑ Yes ❑ No
   Explain: ____
   Has anyone ever commented on your drinking or drug use?
   (Family, friends, or co-workers): .... ❑ Yes ❑ No
   Have any blood relatives of your spouse or children had drinking or drug problem: .... ❑ Yes ❑ No

5. **SEATBELTS:**
   Do you wear a seatbelt when you drive? .... ❑ No ❑ Yes
   ❑ Always ❑ Usually ❑ Seldom ❑ Never

6. **ENVIRONMENTAL EXPOSURE**
   Has your job or hobby ever involved exposure to large amounts of:
   paints, varnishes or chemical solvents, loud noise, asbestos or fiberglass, gasoline powered tools and motors, pesticides, cleaning fluids, soldering or radiation? .... ❑ Yes ❑ No
   If yes, explain: ____________________

7. Do you live with others?.......... ❑ No ❑ Yes

8. Do you find it easy to relax and express feelings? .... ❑ No ❑ Yes

9. Have you had more than one sexual partner in the last five years? .... ❑ Yes ❑ No

10. **CANCER:**
   Have you ever had cancer? .... ❑ Yes ❑ No
   Type: ____________________
   Have any blood relatives had cancer? .... ❑ Yes ❑ No
   Type: ____________________ Which relatives?: ____________________

11. Did your mother take DES (Diethylstilbestrol)? .... ❑ Yes ❑ No

12. **FOR WOMEN:**
   Do you examine your breasts at least once per month? .... ❑ No ❑ Yes
   Do you get minimum daily requirements of calcium? .... ❑ DK ❑ No ❑ Yes
   (Recommendations range from 800-1600 mg per day)
   Have you ever used oral contraceptives/birth control pills? .... ❑ Yes ❑ No
   Have you ever used an IUD (Intra Uterine Device)? .... ❑ Yes ❑ No
   Do you use birth control now? .... ❑ Yes ❑ No
   What type?: ____________________
   Have you had your menopause? .... ❑ Yes ❑ No
   Age: __________

13. **FOR MEN:**
   Do you examine your testicles each month? .... ❑ No ❑ Yes

14. When did you last have the following? **Please list year:**
   ______ physical exam ______ complete eye exam ______ pap smear
   ______ dental exam ______ test for glaucoma ______ mammogram
   ______ blood pressure check ______ hearing test ______ breast exam
   ______ stool test for blood ______ skin test for tuberculosis (tine, mantoux, ppd)
   List any problems or abnormal results related to the above tests:
   ____
   ____

15. **IMMUNIZATIONS:**
   Check the immunizations which you have had and write the last year of injection:
   ❑ tetanus/diphtheria ______ ❑ influenza vaccine ______ ❑ hepatitis B vaccine ______
   ❑ rubella ______ ❑ pneumonia vaccine ______

16. **ALLERGIC REACTIONS:**
   Have you ever had an allergic reaction or side effect to any medications?
   Please list any problems or abnormal results related to the above tests:
   ____
   ____
   Have you ever had any other serious allergic reactions? .... ❑ Yes ❑ No
   (bee sting, asthma, severe poison ivy, specific foods, injections)
   Please list: ____________________
   ____

17. **MEDICATIONS:**
   Do you regularly or frequently take any medications? .... ❑ Yes ❑ No
   (include aspirin, vitamins and minerals, prescription and non-prescription)
   Please list: ____________________
   ____
   (Please bring all your medications with you to your physical exam.)

18. Please list your physicians within the 3-5 years prior to joining Group Health.

Physician Name and Address	Specialty Type	Last Visit

19. **FAMILY MEMBERS:**
Please list family members (parents, brother(s), sister(s), spouse, children):

Name	Relationship	If alive, indicate health: good - poor	If deceased, indicate age and cause of death

Check and indicate which family member(s) have had the following health problems:
(m-mother, f-father, b-brother, s-sister, a-aunt, u-uncle, g-grandparent)

❏ heart disease ___ ❏ kidney disease ___ ❏ Alzheimer's ___ ❏ miscarriage ___
❏ high blood pressure ___ ❏ stroke ___ ❏ tuberculosis ___ ❏ birth defects ___
❏ diabetes (sugar) ___ ❏ glaucoma ___ ❏ bleeding tendency ___
❏ emphysema ___ ❏ mental illness ___ ❏ other/comments ___________________________________

20. **HOSPITALIZATIONS:**
Please list all hospitalizations: (medical and surgical, biopsies, fractures, obstetric/gynecologic and psychiatric)

Nature of Problem	Date	City and State	Hospital

21. Please check if you had the illness in the past, Check now if you currently have the illness.

	Previous	Now
1. Glaucoma		
2. Thyroid problems		
3. Increased cholesterol		
4. Diabetes (sugar)		
5. Lung problems		
6. Abnormal chest x-ray		
7. Abnormal Cardiogram (EKG)		
8. Heart murmur		
9. High blood pressure		
10. Heart problems		
11. Stroke		
12. Diverticulitis		
13. Hepatitis or liver problems		
14. Colitis (ulcerative colitis, Crohns's)		
15. Irritable bowel syndrome (Spastic Colitis)		
16. Ulcer		
17. Gall bladder disease		
18. Bowel polyp		
19. Problems with pregnancies		

	Previous	Now
20. Kidney or bladder problems		
21. Arthritis		
22. Gout		
23. Epilepsy or seizures		
24. Alcoholism		
25. Bleeding tendency		
26. Polio		
27. Rheumatic fever		
28. Scarlet fever		
29. Sinus infections		
30. Tuberculosis		
31. Pneumonia		
32. Syphilis		
33. Gonorrhea		
34. Other venereal disease		
35. Depression, recurrent		
36. Drug addiction		
37. Mental health		
38. Work related disabilities		

22. Please check the symptoms which you have had during the **past year** and symptoms which are of concern to you **now.**

	Past Year	Now
1. Skin lumps or rash		
2. Non-healing skin sore		
3. Mole that changes color or size		
4. Eye problems		
5. Blurring or loss of vision		
6. Decrease or loss of hearing		
7. Chronic nasal congestion		
8. Dental or denture problems		
9. Toothaches		
10. Hoarseness		
11. Swollen glands		
12. Excessive thirst or appetite		
13. Coughing up blood		
14. Wheezing		
15. Chronic cough		
16. Irregular heartbeat		
17. Leg pain with exertion		
18. Difficulty swallowing		
19. Frequent or persistent heartburn		
20. Frequent or persistent nausea		
21. Frequent or persistent vomiting		
22. Vomiting of blood		
23. Jaundice		
24. Frequent or persistent diarrhea		
25. Black or bloody stool		
26. Constipation		
27. Hemorrhoids		
28. Changes in bowel habits		
29. Painful urination		
30. Loss of urine control		
31. Cloudy or bloody urine		

	Past Year	Now
32. Joint or muscle pain with exertion		
33. Foot problems		
34. Dizziness		
35. Weakness or paralysis		
36. Frequent tingling or numbness		
37. Frequent or severe headaches		
38. Loss of consciousness		
39. Loss of balance/falls		
40. Speech difficulties		
41. Frequent or persistent back pain		
42. Shortness of breath		
43. Chest pain		
44. Swollen ankles		
45. Weight change		
46. Difficulty sleeping		
47. Excessive tiredness		
48. Loss of appetite		
49. Unusual bleeding or bruising		
50. Feelings of tension or unhappiness		
51. Problems with sexual activity		
52. Difficulty concentrating		
For Men: 53. Sores on or discharge from penis		
54. Difficulty urinating		
55. Pain or swelling in testicles		
For Women: 56. Unusual vaginal bleeding		
57. Vaginal discharge		
58. Hot flashes		
59. Pain or lump in breast		
60. Discharge from nipples		
61. Difficulty with menstrual periods		

Other:

23. Check those items you would like to discuss with a health professional.

- ❑ family
- ❑ work
- ❑ exercise
- ❑ diet/food intake
- ❑ cancer signs
- ❑ high blood pressure
- ❑ emotional control
- ❑ grieving
- ❑ stress/anxiety
- ❑ anger
- ❑ depression
- ❑ menopause
- ❑ alcohol use
- ❑ drug use
- ❑ smoking
- ❑ venereal disease
- ❑ AIDS
- ❑ herpes
- ❑ services for elderly
- ❑ osteoporosis
- ❑ retirement
- ❑ living will
- ❑ sexually transmitted disease
- ❑ sex
- ❑ parenting
- ❑ infertility
- ❑ premenstrual syndrome
- ❑ birth control
- ❑ Other (please specify): ____________________________________

What do you think you can do to improve or maintain your health? ____________________________________

Thank you for answering this questionnaire. The Provider will fill out the remainder of the questionnaire.

Date ______________ Provider ____________________________________ Center ____________________

30% overweight? ❑ Yes ❑ No

Ht	____________	Wt.	____________	BS	____________
BP	____________	EKG	____________	CBC	____________
Vision: R	____________	Audiogram	____________	Cholesterol	____________
L	____________	WPFT	____________	U/A	____________
dT	____________	CXRAY	____________	Hemoccults	____________
PPD	____________	Mammography	____________	Other	____________

LPN Signature ____

Mental status screen: ____________ items recalled, Spelling: f _______ b ______

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