Health Questionnaire

PRIMARY CARE (719) 522-1133

DaVita Medical Group

Please help us in meeting your health care needs by providing the following information.
****Children under 13, please use Pediatric Health History only. Thank you!***

Patient: _____ Today's Date: _____

Date of Birth: _____ Who is your visit with? _____

What is your reason for coming in today?

_____

PAST MEDICAL HISTORY:

List all *medical illnesses you have had, including the date of diagnosis:*

Illness/Medical Condition:	***Treated by:***	***Date:***

List any surgeries you have had, including dates if known:

Surgery:	***Treated by:***	***Date:***

List any medications you are now taking, including all non-prescription, over-the-counter, vitamins and herbal:

Medication:	***Dose:***	***How Taken:***

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Patient Name: _____ **Date of Birth:** _____

ALLERGIES

Drugs/medications: _____

Known food allergies: _____

Have you ever had any of the following health maintenance testing? (If so, enter date or year):

Mammogram: _____ Colonoscopy:_____ DEXA (Bone Scan): _____

Chest X-Ray: _____ EKG: _____ PAP: _____

Lab(s): *cholesterol* _____ *blood sugar* _____ *thyroid* _____ *other:*_____

IMMUNIZATIONS Please list the immunizations you have had, noting the estimated date.

_____**Tetanus** _____ **Polio** _____ **Pneumovax** _____ **Hepatitis**

_____**Shingles** _____ **Influenza** _____**Measles/Mumps/Rubella**

SOCIAL HISTORY: (Circle one)

Marital Status: Single Married Separated Divorced Widowed

Use of Alcohol: Never Rarely Moderate Daily

Use of Tobacco: Never Previously, but quit _____ Current: packs/day _____

Use of Vapors/E-Cigs: Never Type/frequency: _____

Use of Marijuana: Never Frequency: _____

Use of Drugs: Never Type/frequency: _____

Excessive exposure at home or work to: Fumes Dust Solvents

Airborne particles Noise

Are you on any special diet? If so, what type of diet? _____

Do you think you eat nutritiously? ◻ yes ◻no, why _____

Are you concerned with your weight? ◻no ◻yes

Do you exercise regularly? ◻no ◻yes, what type? _____

SEXUALITY: Gender: ◻Male ◻Female

How do you identify? ◻Heterosexual ◻Lesbian ◻Gay ◻Transgender ◻Bi-sexual ◻Other

Are you sexually active? ◻yes ◻no Any concerns? _____

MEDICAL HISTORY

Family Medical History:

Mother's Age: _____ **Deceased?** ◻**No** ◻ **Yes, cause of death:** _____

Father's Age: _____ **Deceased?** ◻**No** ◻ **Yes, cause of death:** _____

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Patient Name: _____ **Date of Birth:** _____

CONDITION	CIRCLE ONE		WHICH FAMILY MEMBER?
High Blood Pressure	**No**	**Yes**	_____
Heart Disease	**No**	**Yes**	_____
Diabetes	**No**	**Yes**	_____
Cancer	**No**	**Yes**	_____
Kidney Failure	**No**	**Yes**	_____
Mental Illness	**No**	**Yes**	_____
Alcoholism	**No**	**Yes**	_____
Tuberculosis	**No**	**Yes**	_____
Thyroid	**No**	**Yes**	_____

Are there any other illnesses that run in your family? _____

Menstrual History: **WOMEN ONLY**

How old were you when you started your periods? _____

Are you post-menopausal? ☐no ☐yes, date of last period _____

Are your periods regular? ☐yes ☐no, explain _____

If regular, how many days lapse between your periods

(for example, the average cycle is 28 to 32 days) _____

How many days do you flow? _____ Describe flow _____

Do you suffer from menstrual cramps or other menstrual problems? ☐no ☐yes, explain_____

Pregnancy History ***If you have ever been pregnant, please answer the following:***

How many children do you have? _____ Number of abortions or miscarriages: _____

Did you have any complications with your pregnancies? ☐no ☐yes, explain _____

Have you had an ectopic pregnancy? ☐no ☐yes, how many? _____

What form of birth control are you using (i.e., Pill, IUD)? _____

Do you have a "Living Will" and/or "Advanced Directives"? **☐No** **☐Yes (if so, please provide a copy)**

Would you like information on these documents? **☐No** **☐Yes**

Authorization & Release:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health and it is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of patient (or parent/guardian if minor) **Date**

Pediatric Health History

FAMILY MEDICINE 719-522-1133

DaVita Medical Group

MRN: _____ *(Office use only)*

Patient Name: _____ **Date of Birth:** _____

Name child goes by: _____

ALLERGIES: ☐ NONE

Medication: _____

Food: _____

Environmental: _____

MEDICATIONS: ☐ NONE

Prescription: _____

Over-the-Counter: _____

DIET: Infant: ☐ Breast ☐ Formula: _____

Child: ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten-free

☐ Other: _____

IMMUNIZATIONS: ☐ Up-to-Date ☐ Behind ☐ NONE

ACTIVE MEDICAL PROBLEMS: ☐ NONE

☐ Asthma ☐ Allergies ☐ ADHD ☐ Eczema ☐ Diabetic ☐ Seizures ☐ Ear Infections

☐ Bed Wetting ☐ Constipation ☐ Recurrent UTI ☐ Hypertension

☐ Concussions ☐ Depression ☐ Glasses

☐ Developmental Delay: ☐ Speech ☐ Gross Motor ☐ Fine Motor ☐ Social

☐ Other: _____

PAST MEDICAL:

Birth History: ☐ Vaginal ☐ C-section ☐ Weight: _____

☐ Term ☐ Preterm: _____weeks

Medical History: ☐ NONE

Hospitalizations: _____

Specialists seen: _____

Other: _____

Continued next page

Patient Name: _____ **Date of Birth:** _____

Surgical History: ☐ NONE

☐ Ear Tubes ☐ Tonsils ☐ Adenoids ☐ Appendix ☐ Hernia

☐ Other: _____

☐ Fractures: _____

FAMILY HISTORY: ☐ NONE

	Mother	Father	Sibling	Relative
Asthma	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
ADHD	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
	☐	☐	☐	☐

SCHOOL AND ACTIVITIES:

☐ Daycare ☐ Public School ☐ Private School ☐ Home School

Grade: _____ IEP: ☐ Yes

Sports: _____

Activities: _____

FAMILY STRUCTURE:

Parents: ☐ Single ☐ Married ☐ Divorced ☐ Remarried

Custody: ☐ N/A ☐ Joint ☐ Mother ☐ Father

☐ Other: _____

Mother's Name: _____

Father's Name: _____

Step-Parents: _____

Siblings: _____ Age: _____

_____ Age: _____

_____ Age: _____

_____ Age: _____

NAME _____

REVIEW OF SYMPTOMS: Please check any of the following if you are currently experiencing symptoms:

DaVita Medical Group

GENERAL	EYES	ENT	RESPIRATORY	CARDIO
__ Fever	__ Vision problems	__ Ear pain	__ Short of breath	__ Chest pain
__ Chills	__ Red eye	__ Hearing loss	__ Awaken short of breath at night (PND)	__ Palpitations
__ Feeling tired	__ Eye pain	__ Nose bleeds	__ Cough - dry	__ Lower leg swelling
__ Feeling poorly	__ Eye discharge	__ Nasal discharge	__ Short of breath w/ exertion	__ Heart rate slow
__ Weight gain	__ Dry eyes	__ Sore throat	__ Hurts to breathe	__ Lower leg clot
__ Weight loss	__ Itchy eyes	__ Hoarseness	__ Short of breath lying down	__ Heart rate fast
			__ Wheezing	
			__ Cough - productive	

GASTRO	URINARY	REPRODUCTIVE	MUSCULOSKELETAL	NEUROLOGICAL
__ Abdominal pain	__ Pain w/urination	__ Painful menstrual cycle	__ Joint pain	__ Headaches
__ Constipation	__ Urination at night	__ Vaginal discharge	__ Joint swelling	__ Confused
__ Heartburn	How often?_____	__ Pain w/intercourse	__ Joint stiffness	__ Dizziness
__ Vomiting	__ Hesitancy	__ Abnormal vaginal Bleeding	__ Limb pain	__ Fainting
__ Blood in stool	__ Loose bladder Control	__ Testicular pain	__ Limb swelling	__ Limb weakness
__ Nausea	__ Flank pain	__ Erectile dysfunction		__ Convulsions
__ Diarrhea	__ Pass kidney stones	__ Premature ejaculation		__ Difficulty walking
__ Difficulty swallowing	__ Pelvic pain	__ Genital lesions		__ Numbness upper extremity
		__ Decreased libido		__ Numbness lower extremity

INTEGUMENTARY	PSYCHIATRIC	ENDOCRINE	HEM/LYMPH	ALLERGY
__ Skin lesions	__ Depression	__ Feels weak	__ Bleeds easily	__ Allergic reaction
__ Skin wound	__ Suicidal	__ Hot flashes	__ Bruises easily	__ Recurrent infection
__ Itching	__ Anxiety	__ Muscle weakness	__ Swollen glands	
__ Change in mole	__ Sleep disturbances	__ Deeper voice	__ Swollen glands in neck	
__ Skin rash	__ Personality changes	__ Bulging eyes (proptosis)		
__ Dry skin	__ Emotional problems			
__ Breast pain				
__ Breast lump				

NAME _____

REVIEW OF SYMPTOMS: Please check any of the following if you are currently experiencing symptoms: