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:***

Continued next page

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:** _____

Continued next page

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**