Galichia MEDICAL GROUP

Patient Health History Questionnaire

Patient Name:_____ Date: _____

Date Of Birth:_____ Age:_____ Occupation:_____

What Sex were you assigned at Birth? (CIRCLE) Male Female Decline to Answer - What is your current gender identity? (CIRCLE) Male Female Male to Female (transgender female) Female to Male (transgender male) Genderqueer (neither exclusively male or female) Other Gender Category Decline to Answer

Marital Status: S M W D Ethnic Origin:_____ Primary Care Physician:_____

EMERGENCY CONTACT: (not in same household):_____ Phone:_____

RELEASE OF INFORMATION: I give permission to release my medical information to:___No One ___Spouse- *list name*_____

___Other *(list names & relationship to you)*_____

I give permission to leave message at my home phone number and /or on my answering machine concerning:

___Test Results ___Appointment Time / Dates ___Procedure Results

IMMUNIZATIONS

	Yes	Year	Unsure	Never		Yes	Year	Unsure	Never
Flu Shot					Oral Polio				
Hepatitis B Vaccine					Rubella				
Pneumonia Vaccine					TB Test				
Other:					Tetanus				

PERSONAL / FAMILY HISTORY:

# of Siblings:_____ # of Children:_____

Father (living) (died) Age___ Cause_____

Mother (living) (died) Age___ Cause_____

Place an "X" in the column if you (or your family) have ever had the condition listed.

CODES: Father - F Mother - M Brother / Sister - S Grandparent - GP	SELF	FAMILY	When? (Year)	Who?	CODES: Father - F Mother - M Brother / Sister - S Grandparent - GP	SELF	FAMILY	When? (Year)	Who?
Allergies					Heart Disease				
Anemia					Heart Murmur / Valve				
Arthritis					Hepatitis				
Asthma/emphysema					High Blood Pressure				
Back Disorders					HIV (Aids)				
Backache					Indigestion				
Black Tarry Stools					Irregular Heart Beat				
Bleeding Disease					Kidney Infection				
Blood in Stool					Kidney Stone				
Blood in Urine					Leg Pain				
Cancer					Lung Disease				
Change in Bowel Habits					Lyme Disease				
Chest Pain					Nervous Disorder				
Colitis					Painful Urination				
Constipation					Paralysis				
Convulsions					Phlebitis				
Coronary Artery Disease					Pleurisy				
Cough					Pneumonia				
Coughing Blood					Pus in Urine				
Depression					Rheumatic Fever				
Diabetes					Fever				
Diarrhea					Shortness of Breath				
Difficulty Swallowing					Sleep Disorders				
Dizziness					Stroke				
Double Vision					Swelling of Feet				
Enlarged Heart					Swollen Joints				
Epilepsy					TB (Tuberculosis)				
Fainting Spells					Painful Joints				
Freq Urination At Night					Thyroid Disease				
Gallstones					Ulcer				
Gall Bladder Problem					Venereal Disease				
Glaucoma					Vomited Blood				
Headaches					Other				
Heart Attack									

Patient Name:_____

EXAMINATION:	Yes	Year	Unsure	Never	Notes / Complications
Breast Exam					
Complete Physical					
Pelvic Exam					
Rectal / Prostate Exam					
BLOOD TESTS:					
Lipid Profile (Cholesterol)					
Fasting Blood Sugar					
HIV Test					
Glucose Tolerance (Diabetes)					
Other (specify)					
X-RAYS:					
Breast Mammography					
Chest X-ray					
Spinal / Back					
Gastrointestinal Series					
Other (specify)					
OTHER TESTS:					
EKG					
PAP Smear (Women)					
Prostate Test (Men)					
Broncoscopy (Lungs)					
Colonoscopy (Large Intestine)					
Stool Occult Blood					
Treadmill Test					
Urinalysis					
Heart Catheterization					
Thallium / Lexiscan - Cardiac					
Sonogram (specify)					
CAT Scan (specify)					
MRI (specify)					
Electroencephalogram					
Nerve Conduction Studies					
Other (specify)					

PERSONAL HABITS:

Please answer honestly. Information is needed to assure the best treatment. All information is **confidential**.

	No	Yes	
Exercise Regularly	❒	❒	Times per week_____ Type _____
Wear Seat Belts	❒	❒	
Drink Coffee/Tea	❒	❒	Amount per day_____ cups / glasses
Drink Colas	❒	❒	Amount per day_____ glasses
Drink Alcohol	❒	❒	Amount per day_____ ounces
Use Illicit Drugs	❒	❒	Amount per day_____
Smoke	❒	❒	Quit (date)_____ packs / day_____ # of years_____
Chew Tobacco	❒	❒	Amount per day_____ how long?_____

Live with_____

Sleep Normal Pattern from_____ am / pm to _____ am / pm

Recreation / Travel_____

Patient Name:_____

OPERATIONS:

	Date	Comments		Date	Comments
Appendix	_____	_____	Intestines	_____	_____
Carotid	_____	_____	Joint / Bone	_____	_____
Gallbladder	_____	_____	Prostate	_____	_____
Heart	_____	_____	Stomach	_____	_____
Hemorrhoids	_____	_____	Tonsils	_____	_____
Hernia	_____	_____	Other	_____	_____
Hysterectomy	_____	_____			

Radiation Therapy - Date_____ Where _____

HOSPITALIZATIONS:

	Description	Year	Hospital
Illness (Kind)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Other (Reason)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

RECURRENT PROBLEMS:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies ❒No Known Medication Allergies

Medicine	Type of Reaction	Allergen (Substance)	Type of Reacton
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT MEDICATIONS: (Please Copy from Prescription Bottle and Include Vitamins and Herbs)

Name	Dosage	How Often?	Name	Dosage	How Often?
Example: Aspirin	*325 mg*	*1 time/day*	_____		
_____					
_____					
_____					
_____					
_____					
_____					
_____					
_____					
_____					
_____					
_____					
_____					
_____					

Patient Name:_____

OTHER INFORMATION:

Have you ever been referred to a specialist? ❒Yes ❒No Please Elaborate

_____

_____

_____

Have you ever been in an accident? ❒Yes ❒No Please Elaborate

_____

_____

_____

Are there any environmental risks involved in your job or home environments?

❒Yes ❒No Please Elaborate

_____

_____

_____

WOMEN ONLY:

Menstral Periods: Age Onset_____ Regular?_____ Date Last Period_____ Age of Menopause_____

Difficulty with Periods? ❒Yes ❒No Specify_____

_____

Pregnancies: # of Children: Born Alive_____ Cesarean_____ Premature_____ Stillborn_____ Miscarriages_____

Describe Complications:_____

_____

_____

MILITARY SERVICE:

Which branch of service did you serve in?_____

Length of enlistment_____ From_____ to _____

Did you sustain any injuries? ❒Yes ❒No Please Elaborate

_____

_____

_____

Please give any other insights and/or information that you feel might be helpful in your care and/or health maintenance.

_____

_____

_____

_____

_____

SIGNATURES:

Person Completing Form:_____Date:_____

Reviewed by (Provider):_____Date:_____