Bella Terra Primary Care

Primary Care Clinics
Patient Questionnaire -- Adult

Last Name:	**First Name:**	**DOB:**	☐**F** ☐**M**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		**Occupation:**	
Previous or referring doctor:		**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Immunizations (Include approximate year or age)			
	☐ Tetanus	☐ Pneumonia/Pneumovax	☐ Hepatitis A
	☐ Influenza (Flu)	☐ Prevnar 13	☐ Hepatitis B
	☐ Gardasil (HPV)	☐ Shingles vaccine/Zostavax	

Past or Present Medical History: (check all that apply to you)			
☐ Alcohol/ Drug problem	☐ Emphysema/COPD	☐ Liver Disease	☐ Blood Clots
☐ Anemia	☐ Heart – Attack	☐ Osteoporosis	☐ Peripheral Artery Disease
☐ Anxiety	☐ Heart–Coronary Artery Dis.	☐ Prostate problem	☐ Neuropathy
☐ Arthritis	☐ Heart- Heart Failure/ CHF	☐ Psychiatric- Depression	☐ Sleep Apnea
☐ Asthma	☐ High Blood Pressure	☐ Psychiatric Disorder--other	☐ Heart Murmur
☐ Atrial Fibrillation	☐ High Cholesterol	☐ Seizure Disorder	☐ Migraines
☐ Dementia	☐ Hypothyroidism (low)	☐ Stroke	☐ Hepatitis
☐ Diabetes	☐ Hyperthyroidism (high)	☐ Ulcers of the Stomach	☐ Diverticulosis
☐ Cancer—	☐ Kidney Disease	☐ STD/ sexual infection	☐ Colon Polyps
Type:		☐ Abnormal Pap Test	☐ Positive TB test

Surgeries (Include Year or Age at time of surgery)		
☐ Appendectomy	☐ Tonsillectomy	☐ C-Section (Cesarean)
☐ Cardiac Bypass (CABG)	☐ Hernia Repair	☐ Hysterectomy- Partial
☐ Cardiac Angioplasty/Stent	☐ Prostate Surgery	☐ Hysterectomy- Total
☐ Gallbladder Laparoscopic	☐ Vasectomy	☐ Tubal Ligation
☐ Gallbladder Open	☐ Cataract Surgery: ☐ Left ☐ Right	☐ Breast Surgery: ☐ Left ☐ Right
☐ Orthopedic (type):		
☐ Other Surgery:		

Screening Tests	Approx Date:			Approx Date:		
Cholesterol Test		☐ Normal ☐ Abnormal	Pap Smear		☐ Normal ☐ Abnormal	
Colonoscopy		☐ Normal ☐ Abnormal	Mammogram		☐ Normal ☐ Abnormal	
Prostate Test		☐ Normal ☐ Abnormal	Bone Density Test		☐ Normal ☐ Abnormal	
Dental Exam		☐ Normal ☐ Abnormal				
Eye Exam		☐ Normal ☐ Abnormal	☐ Glasses ☐ Contacts ☐ Cataracts			

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MEDICATIONS: List prescribed and over-the-counter medications.		
DRUG NAME:	DOSE & DIRECTIONS:	REASON:

ALLERGIES/ REACTIONS to Medications:	
DRUG NAME:	REACTION/ COMMENTS:
LIST ANY FOOD OR ENVIRONMENTAL ALLERGIES AND REACTIONS:	

SEXUAL HEALTH			
☐ Sexually active	☐ Not currently sexually active	☐ Never sexually active	# partners in past year:
History of Sexually Transmitted Infection ? ☐ No ☐ Yes Type/date:			
Current contraception method:		Previous methods:	
# children:	**For Women:** (# pregnancies:) (# miscarriages:) (# abortions:)		

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, 1 - 3x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., work or recreation >3x/week for 30 minutes)

Tobacco	**Cigarette use:**	☐ Never	☐ Former smoker. Quit date or age:	
		☐ Current smoker----	# packs/day:	# years:
	Other tobacco use:	☐ Pipe	☐ Cigars	☐ Chewing tobacco

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Alcohol	Do you drink alcohol? ☐ No ☐ Yes : ☐ 0-1 time/month ☐ 2-4 times/month ☐ every week	
	Each week, how many: Servings of beer? Glasses of wine? Shots/mixed drinks?	
	When did you last have more than 4 drinks in one day? _____	
	Do you feel you should cut down on drinking?	☐ Yes ☐ No
	Do people annoy you by nagging about your drinking?	☐ Yes ☐ No
	Have you ever felt guilty about drinking?	☐ Yes ☐ No
	Have you ever had a morning drink to steady your nerves?	☐ Yes ☐ No

Drugs	Have you used recreational or street drugs within the last 2 years?	☐ Yes ☐ No
	Have you ever used recreational drugs with a needle?	☐ Yes ☐ No

Personal Safety	Do you wear seatbelts?	☐ Yes ☐ No
	Do you have frequent falls?	☐ Yes ☐ No
	Does your house have a working smoke detector?	☐ Yes ☐ No
	Do you experience conflicts in your relationships that take the form of verbally threatening behavior, mental abuse, physical abuse or sexual abuse?	☐ Yes ☐ No

FAMILY HEALTH HISTORY

Family Member			Age	MEDICAL CONDITIONS (Indicate Healthy or: diabetes, high blood pressure, cholesterol, heart disease, stroke, cancer &type)
Mother		☐ Living ☐ Deceased		
Father		☐ Living ☐ Deceased		
Grandmother *Mother's Side*		☐ Living ☐ Deceased		
Grandfather *Mother's Side*		☐ Living ☐ Deceased		
Grandmother *Father's Side*		☐ Living ☐ Deceased		
Grandfather *Father's Side*		☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		

Reviewed by/ Date:

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System Review for Adults---
New Patient or Annual Preventive Visit

Name: **Today's Date:**

Date of Birth:

Check the box if you are currently experiencing any of the following:

GENERAL:
- ☐ Fatigue
- ☐ Fever
- ☐ Weight gain > 10 lbs
- ☐ Weight loss > 10 lbs

SKIN:
- ☐ Rash
- ☐ New/changing skin lesion
- ☐ Nail changes
- ☐ Hair loss

EYES/EARS/NOSE/THROAT:
- ☐ Vision changes
- ☐ Decreased hearing
- ☐ Ear pain
- ☐ Ringing in ears
- ☐ Nasal congestion
- ☐ Nose bleeds
- ☐ Hoarse voice
- ☐ Sore throat
- ☐ Sneezing
- ☐ Sinus problems
- ☐ Lump in neck

RESPIRATORY:
- ☐ Wheezing
- ☐ Difficulty breathing
- ☐ Night sweats
- ☐ Bloody sputum
- ☐ Productive cough
- ☐ Dry cough
- ☐ Shortness of breath

CARDIOVASCULAR:
- ☐ Chest pain
- ☐ Racing heart
- ☐ Irregular heartbeat
- ☐ Shortness of breath
- ☐ Leg pain with walking
- ☐ Ankle or Leg swelling
- ☐ Decreased exercise tolerance
- ☐ Awakening at night due to trouble breathing

GASTROINTESTINAL:
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Trouble swallowing
- ☐ Heartburn
- ☐ Acid reflux
- ☐ Rectal bleeding

MUSCULOSKELETAL:
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Muscle pain
- ☐ Muscle weakness

HEMATOLOGIC:
- ☐ Easy bruising
- ☐ Prolonged bleeding
- ☐ Enlarged lymph nodes

NEUROLOGIC:
- ☐ Headaches
- ☐ Dizziness/vertigo
- ☐ Numbness/tingling
- ☐ Passing out
- ☐ Difficulty walking
- ☐ Seizures
- ☐ Tremor
- ☐ Frequent falls

PSYCHIATRIC:
- ☐ Depression
- ☐ Anxiety
- ☐ Hallucinations
- ☐ Mood swings
- ☐ Suicidal thoughts
- ☐ Insomnia/sleep problems
- ☐ Psychiatric treatment

ENDOCRINE:
- ☐ Change in appetite
- ☐ Cold or heat intolerance
- ☐ Increased thirst
- ☐ Changes in sex drive
- ☐ Hair loss or excess growth

ALLERGIC/IMMUNOLOGIC:
- ☐ Allergy/Hayfever symptoms
- ☐ Itching
- ☐ Frequent infections
- ☐ Exposure to infection

BREAST:
- ☐ Breast lump/mass
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Rash on breast

GENITOURINARY:
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Loss of bladder control
- ☐ Difficulty passing urine
- ☐ Hernia

MEN:
- ☐ Difficulty starting stream
- ☐ Change in urine stream
- ☐ Penile discharge
- ☐ Testicular pain or mass
- ☐ Erection difficulties

WOMEN:
- ☐ Pelvic pain
- ☐ Irregular periods
- ☐ Vaginal discharge
- ☐ Excessive vaginal bleeding
- ☐ Bleeding after menopause
- ☐ Vaginal dryness
- ☐ Hot flashes
- ☐ Pain with intercourse

Reviewed by/Date: