TEST, B (id #20503, dob: 09/10/2015)

TEST, B 09/10/15 #20503

* 5100172w11831 E-HealthHx

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important.
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: ______________________________

Other concerns: ______________________________

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1.____	1.____
2.____	2.____
3.____	3.____

PREFERRED PHARMACIES

Local: ____________ Mail Order: ____________

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.____	1.____	1.____
2.____	2.____	2.____
3.____	3.____	3.____
4.____	4.____	4.____
5.____	5.____	5.____
6.____	6.____	6.____
7.____	7.____	7.____
8.____	8.____	8.____
9.____	9.____	9.____
10.____	10.____	10.____

IMMUNIZATION HISTORY

Date of last tetanus vaccine: ____________

SOCIAL HISTORY

Education ☐ Less than 8th grade
☐ High school ☐ 2 year college
☐ 4 year college ☐ Post graduate

Marital Status ☐ Married
☐ Single ☐ Divorced
☐ Separated ☐ Widowed
☐ Domestic partner
☐ Open relationship

Exercise level
☐ None (no exercise)
☐ Occasional exercise
☐ Moderate exercise
☐ High level exercise

Guns in Home ☐ Y ☐ N
If yes are they Secured ☐ Y ☐ N

Caffeine ☐ None ☐ Occasional
☐ Moderate ☐ Heavy
# of cups/cans per day? ___

Alcohol Do you drink alcohol?
☐ Yes ☐ No
If so, how often?
☐ Occasionally ☐ > 3 times a week
☐ < 3 times a week
how many drinks per week? ____

Drugs Do you currently use recreational or street drugs? ☐ Yes ☐ No
If yes, list:
____
____

Do you have a history of recreational or street drug use ☐ Yes ☐ No

Tobacco Do you use tobacco?
☐ Yes ☐ No
☐ Cigarettes - _____ pks/day
☐ Chew - ___/day ☐ Cigars - ____/day
# of years______
Are you interested in quitting ☐ Y ☐ N
If not currently, did you ever use tobacco?
☐ Yes ☐ No
Year quit:___________

Sexuality
☐ Sexually active
Sexual partner(s) is/are ☐ Female ☐ Male
Do you use Barrier protection ie condoms
☐ Always ☐ Sometimes ☐ Never
Other Birth control method used: ______
☐ Interested in being screened for STD's
☐ Would you like to discuss your gender and/or sexual identity

(FEMALES ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date ______________ ☐ Abnormal
Where performed? ______________________________
Last Mammogram Date ______________ ☐ Abnormal
Where performed? ______________________________
Do you prefer to have pap smears performed at a GYN office, or here in our office? GYN HERE

Age of first menstrual period: ________
Date of last menstrual period ________
Number of pregnancies: ______ births: _______
miscarriages: ______ abortions: ____________
☐ Cesarean sections If yes, then number: ______

PAST MEDICAL HISTORY

Please check all that apply:

☐ Anxiety Disorder
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Blood Clots (or DVT)
☐ Cancer
☐ Coronary Artery Disease
☐ Claustrophobic
☐ Diabetes - Insulin
☐ Diabetes - Non-Insulin
☐ Dialysis
☐ Diverticulitis
☐ Fibromyalgia
☐ Gout
☐ Has Pacemaker
☐ Heart Attack
☐ Heart Murmur
☐ Hiatal Hernia or Reflux Disease
☐ HIV or AIDS
☐ High Cholesterol
☐ High Blood Pressure
☐ Overactive Thyroid
☐ Kidney Disease
☐ Kidney Stones
☐ Leg/Foot Ulcers
☐ Liver Disease
☐ Osteoporosis
☐ Polio
☐ Pulmonary Embolism
☐ Reflux or Ulcers
☐ Stroke
☐ Tuberculosis
☐ Other

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PAST SURGICAL HISTORY

SURGERY	REASON	DATE	HOSPITAL
1. ______	______	______	______
1. ______	______	______	______
3. ______	______	______	______
4. ______	______	______	______

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	____	☐ Alcohol/Drug abuses ☐ Aneurysm ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other ______
Grandfather (maternal)	Y/N	____	☐ Alcohol/Drug abuses ☐ Aneurysm ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other ______
Grandmother (paternal)	Y/N	____	☐ Alcohol/Drug abuses ☐ Aneurysm ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other ______
Grandfather (paternal)	Y/N	____	☐ Alcohol/Drug abuses ☐ Aneurysm ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other ______
Father	Y/N	____	☐ Alcohol/Drug abuses ☐ Aneurysm ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other ______
Mother	Y/N	____	☐ Alcohol/Drug abuses ☐ Aneurysm ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other ______
Brother/Sister	Y/N	____	☐ Alcohol/Drug abuses ☐ Aneurysm ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other ______
Brother/Sister	Y/N	____	☐ Alcohol/Drug abuses ☐ Aneurysm ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other ______
Other:___	Y/N	____	☐ Alcohol/Drug abuses ☐ Aneurysm ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other ______

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REVIEW OF SYSTEMS

Please check all that apply:

Constitutional
- ☐ Exercise Intolerance
- ☐ Fever
- ☐ Weight Gain (____lbs)
- ☐ Weight Loss (____lbs)

Eyes
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change

Date of Last Exam:_________

Ears/Nose/Mouth/Throat
- ☐ Difficulty Hearing
- ☐ Ear Pain
- ☐ Ringing in Ears
- ☐ Frequent Nosebleeds
- ☐ Nose Problems
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Bleeding Gums
- ☐ Dry Mouth
- ☐ Mouth Ulcers
- ☐ Teeth Problems
- ☐ Mouth Breathing
- ☐ Change in Voice
- ☐ Hoarseness

Cardiovascular
- ☐ Arm Pain on Exertion
- ☐ Chest Pain
- ☐ Chest Tightness/Pressure on Exertion
- ☐ Irregular Heart Beats (Palpitations)
- ☐ Known Heart Murmur
- ☐ Light-headed on Standing
- ☐ Shortness of Breath When Lying Down
- ☐ Shortness of Breath When Walking
- ☐ Swelling (edema)

Respiratory
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black or Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Frequent Indigestion
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Constipation
- ☐ Diarrhea

Genitourinary
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Incomplete Emptying
- ☐ Increased Urinary Frequency
- ☐ Urinary Loss of Control
- ☐ Nocturia

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness

Integumentary (Skin)
- ☐ Changes in Moles
- ☐ Dry Skin
- ☐ Eczema
- ☐ Growth/Lesions
- ☐ Itching
- ☐ Jaundice (Yellow Skin/Eyes)
- ☐ Rash

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory Loss
- ☐ Migraines
- ☐ Numbness
- ☐ Tremors
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Male
- ☐ Difficulty with Erections
- ☐ Penile Lesions
- ☐ Penile discharge
- ☐ Testicular lumps
- ☐ Testicular pain

Psychiatric
- ☐ Alcohol Overuse
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Do Not Feel Safe in Relationship
- ☐ Mania
- ☐ Sleep Problems
- ☐ Hallucinations
- ☐ Suicidal Thoughts

Endocrine
- ☐ Fatigue
- ☐ Increased Thirst/Hunger/Urination
- ☐ Hot/Cold Intolerance
- ☐ Change in Hair

Hematologic/Lymphatic
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands

Allergic/Immunologic
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Gynecological
- ☐ Bleeding between periods
- ☐ Heavy periods
- ☐ Extreme menstrual pain
- ☐ Vaginal itching, burning, or discharge
- ☐ Wake in the night to go to the bathroom
- ☐ Hot flashes
- ☐ Breast lump or nipple discharge
- ☐ Painful intercourse

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Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION – PLEASE PRINT

Last Name: **TEST**
First Name: **B**
Middle Name:
Address: **0000**
City: **BATTLE CREEK** State: **MI**
Zip: **14553**
Home Phone: **(269) 781-4421**
Work Phone:
Mobile Phone:**(555) 555-5555**
Sex: **F**
Date of Birth: **09/10/2015**
Social Security No.:
Patient email:
Required by government mandate [although you may refuse]:
Language: **Patient Declined**
Race: **Patient Declined**
Ethnicity: **Patient Declined**
Marital Status: **U**

Guarantor Information (to whom statements are sent)

Name: **B TEST**
Address: **0000**
BATTLE CREEK, MI 14553
Relationship to patient: ______________________
Date of Birth: **09/10/2015**
Social Security No.:
Phone: ( ) _______ - _____________

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone:( ) _______ - _____________

Next of Kin

Name:
Relationship:
Phone:

Other

Patient Referred by:

Primary Care Provider:

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Pharmacy Information:

Name:

Crossroads:

Phone:

Primary Insurance Information

Insurance Plan Name: ***SELF PAY***
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name:
Last Name:
First Name.:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed____ **Date:**____________________

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Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for MARSHALL MEDICAL ASSOCIATES, P.C**

Signed____ **Date:**________________________

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed____ **Date:**________________________

- **I authorize MARSHALL MEDICAL ASSOCIATES, P.C to release medical information required to process my claim**

Signed____ **Date:**________________________

- **I have read and understand the Financial Policy for MARSHALL MEDICAL ASSOCIATES, P.C**

Signed____ **Date:**________________________

- **I authorize MARSHALL MEDICAL ASSOCIATES, P.C to obtain/have access to my medication history**

Signed____ **Date:**________________________

- **I authorize my provider's office to contact me by mobile phone**

Signed____ **Date:**________________________

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FormLett

Marshall Medical Associates
1174 West Michigan Ave
Marshall, MI 49068
Phone: 269-781-9867
Fax: 269-781-9126

I authorize________________________________

to discuss my financial and or medical information and to receive anything that is requested regarding my healthcare.

Signature________________________________Date________

Patient date of birth______________________

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Patient Name: B TEST

☐ **Never Smoked** ☐ **Former Smoker** ☐ **Current Some Day Smoker** ☐ **Current Every Day Smoker** Ready to quit? **Y N**

Adults 50 and older: Ever had a colonoscopy? Y N Approximate month and year_______ Where?________

Women 21 and older: Had a hysterectomy? Y N When____________Where _______________
Have you had a pap smear in the past 3 years? Y N Where_____________When______________. Last pap adnormal? Y N
Have you had a mammogram in the past two years? Y N Where?_______When_____________

If you have **diabetes or high blood sugar:**
Have you had a dilated eye exam in the past year? **Y N** Which eye doctor do you see? ______________________
Do you regularly take cholesterol medication? **Y N**

Adults 65 and older:
History of Falling? **Y N**
Secondary Diagnosis? **Y N**
Ambulatory aid? **Bed rest/nurse assist** **Crutches/cane/walker** **Furniture**
IV/Heparin Lock? **Y N**
Gait/Transferring? **Normal/bedrest/immobile** **Weak** **Impaired**
Mental Status? **Oriented to own ability** **Forgets limitations**

Adults 18 and older: Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or over eating				
Feeling bad about yourself - or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching TV				
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or hurting yourself in some way				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	**Not difficult at all**	**Somewhat difficult**	**Very difficult**	**Extremely difficult**

We want to provide efficient, quality healthcare. Please list any frustrations you experience with the care you receive at our clinic. Examples: difficulty getting an appointment, a question answered, a referral, your refills, your results, etc.

We appreciate your feedback. Please provide us with any additional information about your experience on the back of this form.