



PrimeCare Medical Center

"Our Emphasis is on Quality Healthcare"

Patrick E. Evivie, MD, FACP
Medical Director

Hans Kwaku, MD

Kim Neely, PA-C

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
PREVIOUS OR REFERRING DOCTOR:		DATE OF LAST PHYSICAL EXAM:	

PERSONAL HEALTH HISTORY

CHIEF COMPLAINT:			
Location			
Duration			
Does anything make the problem worse?		Is the problem constant or variable?	

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

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SURGERIES AND OR HOSPITALIZATIONS

Year	Reason	Hospital

HAVE YOU EVER HAD A BLOOD TRANSFUSION?

Yes No

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Internal Medicine, Diabetes Resource Center and Urgent Care

www.primecaremed.org

Phone: 704-335-0806/ Fax: 704-334-2073



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	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you concerned about the amount you drink?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		
Drugs	Do you currently use recreational or street drugs?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?			<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			SIBLING	<input type="checkbox"/> M <input type="checkbox"/> F	
MOTHER				<input type="checkbox"/> M <input type="checkbox"/> F	

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you satisfied with life?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in: <input type="checkbox"/> Weight <input type="checkbox"/> Energy level <input type="checkbox"/> Ability to sleep <input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

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