Geauga Family Physicians

General Health History Questionnaire (age 13 years or older)

If you need more room for a section please write on the back of this form.

Name: _____ _____ _____ **Today's Date** _____/_____/_____
(last) (first) (MI)

Date of Birth ____/____/_____ **Gender: Male** ____ **Female** ____ **Race:** _____

Preferred Language: _____ **Ethnicity: (Not Hispanic/Latino ___) (Hispanic/Latino ___)**

Significant Illnesses

Do you or have you had: (Circle Y for Yes or N for No)

Diabetes	Y	N
Cancer	Y	N
Gout	Y	N
High Blood Pressure	Y	N
Heart Disease	Y	N
Kidney Disease	Y	N
Mental Illness	Y	N
Abnormal Pap	Y	N
Asthma	Y	N
High Cholesterol	Y	N

Other illness not listed:_____

_____

Hospitalizations/Surgeries

(List reasons you were hospitalized)	Year
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Health Screening (Circle Y for yes and N for no)

Have you had		Date of Last
Physical	Y N	_____
Lipid Screening (ages 20+)	Y N	_____
Diabetes Screening (ages 45+)	Y N	_____
Annual Influenza Vaccine	Y N	_____
Tetanus Shot	Y N	_____
MMR Shot	Y N	_____
TB test	Y N	_____
Colonoscopy (ages 50+)	Y N	_____
Hepatitis Vaccine	Y N	_____
Ages 65+		
Glaucoma Screening	Y N	_____
Pneumonia Vaccine	Y N	_____
Shingles Vaccine	Y N	_____
Women Only		
Pap (ages 40-69)	Y N	_____
Mammogram (ages 40 – 74)	Y N	_____
Bone Density 65+	Y N	_____

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Anemia	☐	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Deceased	☐	☐	☐	☐	☐	☐

All Allergies / Reaction

All Allergies	Reaction
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Social History

Tobacco Use

Current Y N # yrs ___ #per day ___

Former Y N # yrs ___ yr quit _____

Alcohol Y N Drinks per day _____

Caffeine Y N Cups/cans per day____

Recreational Drugs Y N Times per week _____

Exercise Y N Times per week _____

Occupation _____

Specialist Seen

(List all specialists from whom you are currently receiving care)

1._____ 3. _____ 5._____

2._____ 4._____ 6._____

Medications with Dosage and Instructions (Please bring in your medication bottles to your appointment)

(List all medications you take on a regular basis including over the counter medications)

1. _____ 4. _____ 7. _____ 10._____

2. _____ 5. _____ 8. _____ 11._____

3._____ 6. _____ 9. _____ 12._____

Your Pharmacy _____ **Location** _____

(example- CVS) (example- Center st, Chardon)

Have you had any of these symptoms in the last month? (Circle Y for yes and N for no)

1) Unexpected weight change Y N	**5) Chest Pain Y N**	**9) Urinary Pain Y N**	**13) Headaches Y N**
2) Fatigue Y N	**6) Palpitations Y N**	**10) Joint Pain Y N**	**14) Frequent thirst Y N**
3) Vision Changes Y N	**7) Shortness of Breath Y N**	**11) Rashes Y N**	**15) Unusual bruising and bleeding Y N**
4) Nasal Congestion Y N	**8) Changes in Bowels Y N**	**12) Dizziness Y N**	**16) Allergy symptoms Y N**

Please answer yes or no to the following questions:

Are you, or have you been, in a relationship in which you feel unsafe? (Yes___) (No___)

Have you or your children been hit or threatened? (Yes___) (No___)

Please answer the following:

Over the past 2 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**
1. Little Interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Do you have any specific communication needs due to visual impairment, hearing impairment, or language spoken?

(Yes___) (No___) If yes please describe: _____

Do you have Advanced Directives? (Y___) (N____) Living Will? (Y___) (N___) If you have Advanced Directives, please bring them to your appointment so that a copy can be made for your Doctor and placed in your medical chart.

Do you have any specific concerns today? Yes___ No___ If yes, please describe _____

_____

_____

Patient's Name _____Date of Birth ____/____/_____ Date ____/____/_____

Reviewed by Physician/Nurse_____ Date: ___/___/_____