Name: _____

DOB: _____

Magnolia Family Practice

Health History Questionnaire

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

NAME: _____**DATE**: _____

Date of Birth: _____

Gender: MALE FEMALE

Referred by: Doctor Friend Previous Patient Other: _____

Marital Status: Single Married Divorced Widowed

Children: NO YES

If yes, number of children? _____

Occupation: _____

Religious preference: _____

Please indicate if you believe any of the items listed below will interfere with your ability to learn about your condition(s) or medication(s):

___No difficulties

___I cannot hear well enough to receive verbal information

___I cannot see well enough to read printed information

___I do not speak English well
___I do not read English well
___I have trouble remembering things

___Other, please specify: _____

Is there someone who needs to interpret for you? No Yes

How do you prefer to learn? Oral instruction ☐ Written instruction ☐
Demonstration ☐

Name: _____

DOB: _____

Magnolia Family Practice

Social History

Please check those applicable to you:

Exercise: None Occasional Regular Vigorous

Type of Exercise: _____

Nutrition:

Any dietary restrictions either self-imposed or recommended by a professional?

_____

What do you eat typically for

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

Alcohol intake: None Occasional Weekly

How many drinks per week? _____

Are you concerned about the amount of alcohol you consume? No Yes

Tobacco intake: Cigarettes Vape Cigars Pipe Snuff/Dip

How much do you smoke/snuff daily? _____

Have you tried to quit?_____ Quit for how long? _____

Relapsed? _____

Would you like to quit? No Yes

Name: _____

DOB: _____

Magnolia Family Practice

Do you currently use recreational or street drugs? No Yes

If so, what do you use_____

How often? _____

Would you like to quit? No Yes

Do you live alone? No Yes

If no, whom do you live with? _____

Do you want Magnolia Family Medicine to leave messages regarding your test results, appointments, or other medical communications with the person you live with?

No ☐ Yes ☐

What is your preference of contact?

At your home: ☐ Yes ☐ No Phone Number _____

At your work: ☐ Yes ☐ No Phone Number _____

Cell phone: ☐ Yes ☐ No Phone Number _____

Do you have Advanced Directives? No ☐ Yes ☐

Do you have any questions about Advanced Directives? No ☐ Yes ☐

Would you like information about Advanced Directives? No ☐ Yes ☐

Do you have a Power of Attorney? No ☐ Yes ☐

Name: _____

DOB: _____

Magnolia Family Practice

Family Medical History

Please list any significant health problems of parents, siblings, and children.

If deceased, please note their age at the time of their passing.

Mother Alive Age	Disease(s)
Father Alive Age	Disease(s):

Medications

Please list all medications both prescribed and over the counter. If you need more room to document, please write on the back side of this form.

Medication	Dose/Frequency

Name: _____

DOB: _____

Magnolia Family Practice

Any ALLERGIES to medications/foods/metals? No ☐ Yes ☐

If yes, what allergies? _____

Name: _____

DOB: _____

Magnolia Family Practice

Medical History.

Please check the box for all that apply

Past surgeries:

Skin ☐Yes ☐No Ex: Rashes Lesions	**Eyes** ☐Yes ☐No Ex: Eye pain/burning Loss of vision Double vision	**Constitutional** ☐Yes ☐No Ex: Fever Weight gain/loss	**Chest/Heart** ☐Yes ☐No Ex: Chest pain Palpitations	**Neurological** ☐Yes ☐No Ex: Memory changes Difficulty walking Slurred speech
Genitourinary ☐Yes ☐No Ex: Urinary frequency Burning with urination Sexual function problems	**Throat** ☐Yes ☐No Ex: Sore throat	**Head/Neck** ☐Yes ☐No Ex: Neck pain Headaches	**Back** ☐Yes ☐No Ex: Low back pain	**Endocrine** ☐Yes ☐No Ex: Excessive thirst Cold/heat intolerance
Gastrointestinal ☐Yes ☐No Ex: Abdominal pain Nausea/vomiting Rectal bleeding	**Hematological** ☐Yes ☐No Ex: Easy brusing Easy bleeding Lymph node swelling	**Psychiatric** ☐Yes ☐No Ex: Depression Anxiety Psychosis	**Lungs** ☐Yes ☐No Ex: Cough Shortness of breath	**Ears/Nose** ☐Yes ☐No Ex: Hearing loss Ringing Nose bleeding

Type of Surgery	Approximate Date of Surgery

Have you ever needed a blood transfusion? No Yes

If yes, what year did you receive a transfusion? _____

Mental Health:

Is stress a major problem for you? No ☐ Yes ☐

Name: _____

DOB: _____

Magnolia Family Practice

Do you feel depressed? No ☐ Yes ☐

Have you ever attempted suicide? No ☐ Yes ☐

Do you have trouble sleeping? No ☐ Yes ☐

Do you have thoughts that you are better off dead? No ☐ Yes ☐

Chronic Pain:

Any falls in the last six months? No ☐ Yes ☐

Please rate pain level in each area of the body on a scale of 0-10, with 0 being NO pain and 10 being UNBEARABLE pain.

Headache	0	1	2	3	4	5	6	7	8	9	10
Neck	0	1	2	3	4	5	6	7	8	9	10
Right arm	0	1	2	3	4	5	6	7	8	9	10
Left arm	0	1	2	3	4	5	6	7	8	9	10
Back	0	1	2	3	4	5	6	7	8	9	10
Right leg	0	1	2	3	4	5	6	7	8	9	10
Left leg	0	1	2	3	4	5	6	7	8	9	10
Stomach	0	1	2	3	4	5	6	7	8	9	10

Other: _____

Date of most recent colonoscopy? _____

History of polyps? No ☐ Yes ☐

History of colon cancer? No ☐ Yes ☐

History of any cancers in the past? No ☐ Yes ☐

If yes, what type of cancer? _____

How many years in remission? _____

Name: _____

DOB: _____

Magnolia Family Practice

What treatment did you receive as treatment for the cancer? _____

History of injuries such as fractures? Crush injuries? No Yes

Date of injury/approximately how many years ago?

_____

What body part(s) are/were affected?

_____

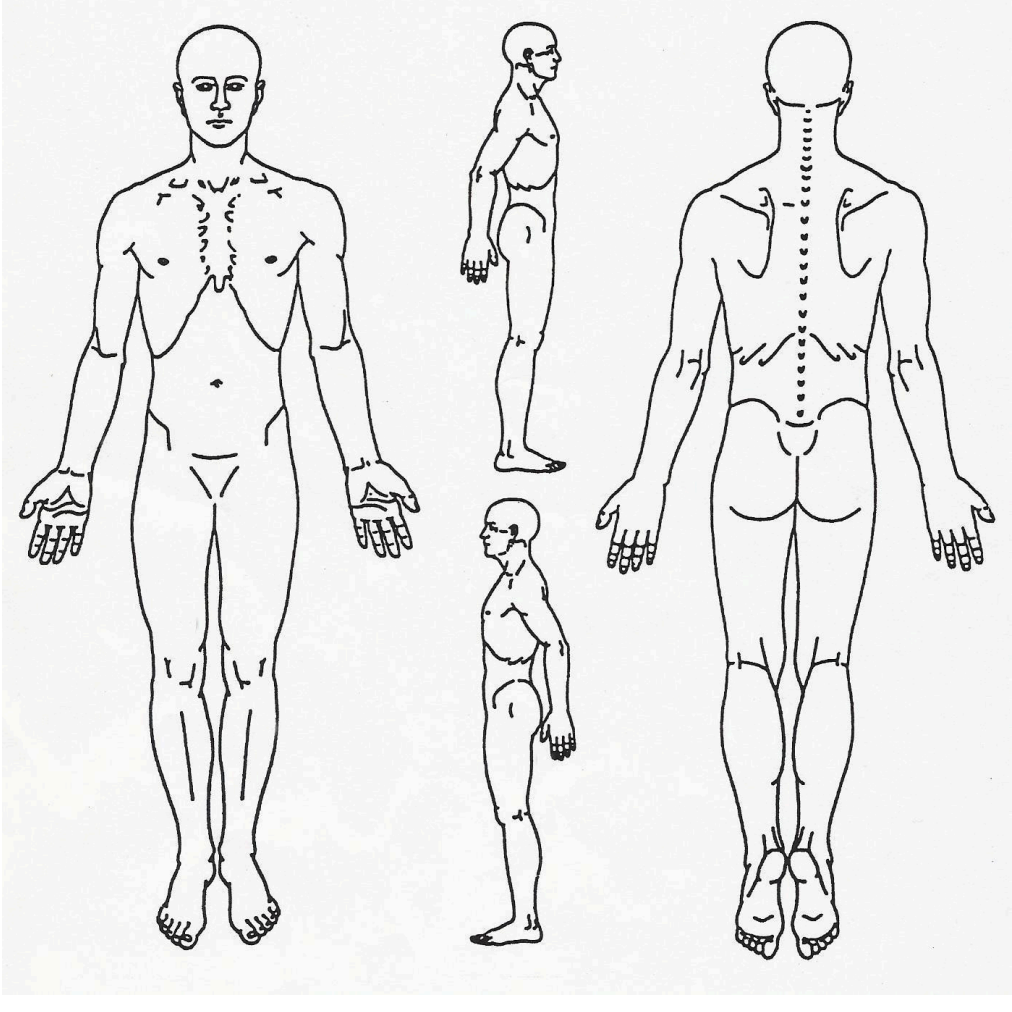
History of neuropathies? No ☐ Yes ☐

What body part(s) are/were affected?

_____

Pain Diagram

Please shade in the area(s) you are experiencing pain



Name: _____

DOB: _____

Magnolia Family Practice

Women's Health

History of breast implants? No ☐ Yes ☐

History of mastectomy? No ☐ Yes ☐

If yes, date? _____

Circle which breast(s): Right ☐ Left ☐

Date of last menstrual cycle: _____

Last Pap:

History of a hysterectomy? No ☐ Yes ☐

If yes, date? _____

History of bone density scan?

Date of most recent bone density scan? _____

History of Osteoporosis? No ☐ Yes ☐

Treatment for Osteoporosis: _____

By signing below, you certify that the included information is accurate and inclusive of all information relevant to your care.

Patient Signature: _____Date: _____

Printed Name: _____