Beach Midway Med Express

HEALTH QUESTIONNAIRE

NAME: ____BIRTH DATE: ___/___/_______DATE:____/___/________

Gender: ______Male _____Female Age: ______Pregnant? _____Breastfeeding?

REASON FOR VISIT TODAY____
List all your current medications, including non-prescription drugs: ____None

____________________________ ____________________________ ____________________________
____________________________ ____________________________ ____________________________
____________________________ ____________________________ ____________________________
____________________________ ____________________________ ____________________________

Medication Allergies: ____ **YES** **No known allergies______**

Medication	**Reaction**

HOSPITALIZATION & SURGERY (Check all that apply, specify and write in date below) ___ NONE APPLY

____Appendix________________ ____Heart________________ ____Tubal Ligation______________
____Adenoids________________ ____Hernia_______________ ____Vasectomy ________________
____Back____________________ ____Hysterectomy________ ____C-Section_________________
____Breast__________________ ____Tonsillectomy_________ ____Implanted device (specify) _____________
____Gallbladder Surgery______ _____Fractured Bones ____
____Other____
____

Past Medical History and Review of Systems

Please check off if you have had any problems with or are presently experiencing any of the following:

___Alcohol abuse
___Asthma
___Arthritis
___Anemia
___Anxiety
___Abdominal discomfort
___Blood disorder
___Blood in stool
___Bronchitis
___Cancer
___Chest pain/chest tightness
___Change in bowel habits
___Colitis
___Constipation
___ Depression
___Diabetes
___Diarrhea
___Difficulty urinating
___Drug abuse
___Emphysema/COPD
___Epilepsy
___Frequent urination
___Gall Bladder disease
___ Gout
___Heart disease
___Head or neck radiation
___Headache
___Hay Fever
___Hemorrhoids
___Hepatitis or jaundice
___High blood pressure
___History of blood transfusion
___Indigestion (Reflux/Gerd)
___Impotence or Erectile Dysfunction
___Kidney disease
___Kidney stones
___Lightheadedness
___Low back pain
___Nausea
___Palpitations
___Persistent cough
___Pneumonia
___Rheumatic fever
___Shortness breath
___ Skin Disease
___Stroke
___Swollen ankles
___Sleepapnea
___T.B
___Thyoid disease
___Ulcers
___Unexplained weight gain/loss
___Venereal disease or STDS
___Insominia
___High Cholesterol

OTHER:
____
____

Marital Status: ____Single ____Married ____Divorced ____Widowed
Years Married: ____ Children: Females____ Males: _____
Do you smoke: ____No ____Yes _______packs/day

For the Minor patient:
Child lives with: _____Parents ____Grandparents
Other? ____________________________________

Have you ever smoked: ____Yes ____No Quit: ____________________________________

Do you drink alcoholic beverages: ____No ____Yes? How much per week? ______________________

Do you use any recreational drugs or medications not prescribed to you? ____No ____Yes

Patient Name: ___________________________

Birth Date: ______________________________

Family History: **Please give approximate date of onset of each disease, if known:**

Age if living or Age of deceased

	Father	Mother	Bro___ Sis___	Bro___ Sis___	Bro__ Sis___	Bro___ Sis___
AGE						
Deceased						
Cancer(type)						
Diabetes						
Heart Attack						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Stroke						
Thyoid Disease						
Other						
No medical problems						

Immunizations

Tetanus ___yes ___no Date vaccinated ________

Influenza ___yes ___no Date vaccinated ________

Pneumococcal ___yes ___no Date vaccinated ________

Hepatitis A Series ___yes ___no Date vaccinated ________

Hepatitis B Series ___yes ___no Date vaccinated ________

Gardasil Series (HPV) ___yes ___no Date vaccinated ________

Zoster Vaccine ___yes ___no Date vaccinated ________

Varicella ___yes ___no Date vaccinated ________

Chicken Poxs? ___yes ___no

PREVENTION

Do you wear seat belts? ___Yes ___No If no, why not? ____

Do you wear bike helmet? ___Yes ___No ___ N/A

Do you exercise regularly? ___Yes ___No If yes, type, duration and number of times per week?___________
____

Do you drink coffee, tea, and/or energy drinks? ___Yes ___No How much per week?____________________________________

Do you wish to be tested for AIDS? ___Yes ___No

Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? ___Yes ___No If yes, explain:____

Have you ever worked with chemicals, paints, asbestos or other hazardous materials? ___Yes ___No If yes, explain____

Do you have a "living will"? ___Yes ___No

Method of birth control? ___Yes ___No

Do you have any **TATTOOS?** ___Yes ___No If yes, identify which body part:______________________________

Would you like information about Advance Directives or Living Will? ____YES ____NO ______INITIALS DATE:_____________

List all other symptoms you are experiencing that you need to discuss:
____
____

I have read the above information and consent that it is correct to the best of my knowledge. I authorize Beach Midway Med Express and its health care providers to render necessary treatment for my condition.

____ _________________________________

Signature of Patient/Guardian Date

This form has been reviewed by the treating physician:

____ _________________________________

Signature of Physician Date

Patient Name: ___________________________

Birth Date: ______________________________

VACCINATION HISTORY	CHECK IF VACCINATED FOR: HEPATITIS B ____ TETANUS____ MUMPS____ MEASLES____ RUBELLA____ MMR____
	HAVE YOU RECEIVED TUBERCULOSIS SKIN TEST? ____YES ____NO

DO YOU PURSUE ANY OF THE FOLLOWING HOBBIES?

HOBBY	YES	NO	HOBBY	YES	NO	HOBBY	YES	NO	HOBBY	YES	NO
PAINTING			RESTORE OLD HOUSES			POTTERY			CARPENTRY		
POLISHING			RESTORE OLD FURNITURE			GARDENING			OTHERS? SPECITY BELOW		
BUILD MODELS			CEMENT WORK			FARMING					

OCUPATIONAL HISTORY: PLEASE CHECK "YES" OR "NO" IF YOU HAVE EVER WORKED IN THE FOLLOWING POSITIONS OR SITUATIONS

JOB TITLE	YES	NO	JOB TITLE	YES	NO	JOB TITLE	YES	NO
GRINDER			IN A MINE			AS A SANDBLASTER		
PAINT SPRAYER			WITH CHEMICALS			WITH FIBERGLASS		
FOUNDRY WORKER			WITH LEAD EXPOSURE			IN ELECTROPLATING		
NEAR COKE OVEN			WITH CHROMIC ACID			JACKHAMMER		
WELDER			WITH RADIOACTIVE MATERIALS			POTTER WORKER		
WITH ASBESTOS OR			AS A METAL CHIPPER			OTHER HAZARDOUS		