Stormont-Vail Health*Care* & Cotton-O'Neil Clinic

Patient Medical Questionnaire

Name: _____ **Birthdate:** _____ **Today's Date:** _____

Primary Care Physician: _____

Reason for visit (circle): New Patient / Consult / New Problem _____

Current or past medical problems (circle): Asthma / COPD / Allergies / Arthritis / Cancer / Diabetes / Thyroid problems / High Blood Pressure / Heart Disease / High Cholesterol / Menstrual problems / Anxiety / Depression / GERD / Kidney Disease / Seizures / Skin problems / Chicken Pox
Others: _____

List all medications, doses and prescriber. Include over-the-counter medications or supplements:

_____ _____

_____ _____

_____ _____

_____ _____

Allergies or intolerance to medications:

_____

_____

Please circle:

Marital Status: Divorced / Legally Separated / Life Partner / Married / Significant Other / Single / Widowed
Race - you may circle 2, but list 1st, then 2nd: - American Indian and Alaskan / Asian / Black or African American / Hispanic / Native Hawaiian or other Pacific Islander / Other / Prefer not to answer / White or Caucasian
Ethnicity: Hispanic / Non-Hispanic / Prefer not to answer
Preferred language: English or _____

Tobacco use or exposed to Passive Smoke: Current everyday smoker / Current some day smoker / Former smoker / Heavy tobacco smoker / Light tobacco smoker / Never smoked / Passive smoke exposure—never smoked
Smoking tobacco type: Cigarettes / Pipe / Cigars / E-Cig
How many packs per day: _____ How many years ? _____ Started when? _____
Smokeless tobacco use: Current user / Former user / Never used
Ready to quit? Yes / No

Last menstrual cycle _____ / Post-Menopausal / Pregnant / Breastfeeding Last Pap _____

Most recent immunizations: Tetanus _____ Whooping Cough _____
Pneumonia _____ Shingles _____
HPV vaccine (Gardisil) _____ Do you get a flu shot annually? Yes / No
Other Immunizations: _____

Last Mammogram _____ **Last Colonoscopy** _____

Continued on reverse…

Prior hospitalization or surgeries — when, where, which surgeon (if you remember)

_____

_____

_____

Family History:

Label sibling or child: sister as S, brother as B, daughter as D, sons as S

Add maternal grandparents as MGM and MGF, paternal grandparents as PGM and PGF

Name	Alive?	Healthy	Alcoholism	Arthritis	Asthma	Cancer	COPD	Depression	Diabetes	Drug Abuse	Early Death	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Stroke	Thyroid Disease	Vision Loss	OTHER	ADHD	Allergic Rhinitis	Anxiety	Dementia	Colon Polyps	GERD	Migraines	Kidney Stones	Things in Family		
Mother																															
Father																															
Sibling																															
Sibling																															
Sibling																															
Child																															
Child																															
Child																															

Social History:

Alcohol use — Yes / No Number of: ___ glasses wine per week ___ shots/mixed drinks per week ___ cans beer per week

Drug use: Yes / No If yes, how much per week: ____ which type: marijuana / meth / cocaine / IV / other

Are you sexually active: No / Not currently / Yes If yes, with a: Male / Female / Both

Which birth control (circle): Abstinence / Coitus Interruptus / Condom / Diaphragm / Implant (Nexplanon) / Injection (Depo) / IUD / Oral Contraceptive Pills / Patch / Post-Menopause / Rhythm / Spermicide / Surgical / Vasectomy / Tubal / Other / None

Occupation: _____ **Employer:** _____

Currently living with: Alone / Spouse / Friends / Attendant / Family _____

If there is anything else we need to know that is not covered, please list here.

_____

_____

If you must cancel your appointment, please notify us as soon as possible. We appreciate notification of cancellations with more than 24 hours prior to scheduled appointment; this allows us to schedule other patients who need care. We are obligated to record all cancellations and no-show in your medical record.

Person filling out form if not the patient: _____