ROPER ST. FRANCIS PHYSICIAN PARTNERS

Date: _____

Patient Name: _____ DOB: _____

Reason for today's visit: _____

Health Questionnaire: Please √ all that apply

	Past	Now		Past	Now		Past	Now
Angina			Emphysema/Bronchitis			Migraines/Headaches		
Anxiety/Nerves			Epilepsy/Seizures			Pneumonia		
Arthritis/Rheumatism			Fibrocystic Breast Disease			Prostate Disease		
Asthma			Gallstones			Psoriasis		
Black or tarry looking stools			Glaucoma			Rectal bleeding		
Blood Clots			Hearing change			Sickle Cell Disease		
Blood Disorder/Anemia			Heart Attack			Skin rash		
Cancer			Heart Failure			Stroke		
Chest pain			High Blood Pressure			Thyroid/Goiter		
Colitis/Bowel Problem			Insomnia			Tuberculosis		
Dementia/Alzheimer's			Irregular Heart Beat			Vomiting		
Change in bowel habits			Joint pain			Ulcers		
Depression			Kidney Disease/Stone			Urinary frequency		
Diabetes			Liver Disease/Hepatitis			Urinary Infections		
Diarrhea			Mental Illness			Weight Loss ____ lbs		
Dizziness			Nausea			Weight Gain ____ lbs		
			Nose bleeds			Wheezing		

Did any of the above checked require hospitalization? Please note _____

_____

_____

_____

Surgical History: Please √ all that apply

□	Cholecystectomy	□	Hernia surgery
□	Hysterectomy with/without ovary removal	□	Colon/Bowel surgery
□	Appendectomy	□	Previous anorectal surgery
□	Breast Surgery	□	Other:
□	Heart/Lung Surgery		

Family History of Cancer □ No family history of malignancies

			Age diagnosed
Colorectal Cancer	□ Yes □ No	Who?	
Breast Cancer	□ Yes □ No	Who?	
Uterine Cancer	□ Yes □ No	Who?	
Ovarian Cancer	□ Yes □ No	Who?	
Brain Cancer	□ Yes □ No	Who?	
Bladder Cancer	□ Yes □ No	Who?	
Prostate Cancer	□ Yes □ No	Who?	

Other Medical Disorders of Family Members **Please √ all that apply**

□	Crohn's Disease	□	Alzheimer's Disease
□	Ulcerative Colitis	□	Migraines
□	Alcoholism	□	Osteoporosis
□	Asthma	□	Stroke
□	Bleeding Problems	□	Tuberculosis
□	High Cholesterol	□	Hypertension (High Blood Pressure)
□	Diabetes	□	Kidney Disease
□	Heart Attack	□	Mental Illness

Social History

I am: □ Single □ Married □ Widowed □ Divorced
Mother: □ Living □ Deceased Cause _____
Father: □ Living □ Deceased Cause _____
How many sons? _____ Any health issues? _____
How many daughters? _____ Any health issues? _____
Work? □ Yes □ No □ Full time □ Part time □ Retired □ Student □ Other: _____
Smoke □ Yes Packs per day _____ □ No □ Quit When _____
Alcohol □ Yes □ No Type: □ Beer □ Heavy Liquors □ Wine Amount _____
Illegal Substances □ Yes □ No Type _____
Height _____ ft _____ inches Weight _____ lbs
Any dietary restrictions? □ Yes □ No Type _____

FEMALES ONLY

Last Menstrual Period _____ Birth Control □ Yes □ No Type _____
Interval (days) _____ Duration (days) _____ Date of last Pap/pelvic exam _____
Estrogen Replacement Therapy □ Yes □ No Type _____
Number of Pregnancies _____ Live Births _____ Abortions _____
Forceps used for delivery _____ (number of times) Episiotomy _____ (number of times)

MEDICATION ALLERGIES AND REACTIONS

NAME OF MEDICATION	REACTION

Current Medications and Dosages

NAME OF MEDICINE	DOSAGE/ INSTRUCTION	NAME IF MEDICINE	DOSAGE/ INSTRUCTION

Health Screenings

TEST	DATE	DOCTOR	RESULTS
Mammography			
Colonoscopy Flexible Sigmoidoscopy			
Prostate screening (PSA)			

ROPER ST. FRANCIS
PHYSICIAN PARTNERS

Advanced Health Directives

Have you designated anyone to function as your legal guardian or decision maker (by completing a "Living Will" or "Power of Attorney" form) in the event that you are unable to make decisions regarding your health care?

□ Yes □ No

List individual below:
Name _____ Relation _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____) _____

Have you discussed or made a decision regarding the use of life sustaining measures if the need should arise? (I.e. CPR/chest compressions, electric shocks to the heart, brain, breathing machine/respirator)

□ Yes □ No

By signing below, I testify that all the information provided is the most accurate to the best of my knowledge.
Patient Signature _____ Date _____

Patient Representative Signature _____ Date _____

By signing below, I certify that I have reviewed the information provided in this Health Questionnaire.	
_____	_____
Physician Signature	**Date**

Name: _____ **DOB:** _____