PERFECTSENSE care management

Original Date: _____/_____/_____
Dates Revised: _____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____

HEALTH HISTORY QUESTIONNAIRE

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

Name: *(Last, First, M.I.)* ☐ **M** ☐ **F** **DOB** _____/_____/_____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Previous or Referring Doctor: **Date of Last Physical Exam:** ___

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and Dates:
☐ Tetanus _____ ☐ Pneumonia _____
☐ Hepatitis _____ ☐ Chickenpox _____
☐ Influenza _____ ☐ MMR _____
Measles, Mumps, Rubella

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion? ..... ☐ Yes ☐ No

Please turn to next page

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name the Drug	Strength	Frequency Taken

Allergies to Medications:

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise:
☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.)
☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet:
Are you dieting? ☐ Yes ☐ No
If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No
# of meals you eat in an average day?_____
Rank Salt Intake ☐ Hi ☐ Med ☐ Low Rank Fat Intake ☐ Hi ☐ Med ☐ Low

Caffeine:
☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day? _____

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Alcohol:
Do you drink alcohol? ☐ Yes ☐ No
If yes, what kind?_____ How many drinks per week? _____
Are you concerned about the amount you drink? ☐ Yes ☐ No
Have you considered stopping? ☐ Yes ☐ No
Have you ever experienced blackouts? ☐ Yes ☐ No
Are you prone to "binge" drinking? ☐ Yes ☐ No
Do you drive after drinking? ☐ Yes ☐ No

Tobacco:
Do you use tobacco? ☐ Yes ☐ No
☐ Cigarettes - Pks/day_____ ☐ Chew - #/day _____ ☐ Pipe - #/day _____
☐ Cigars - #/day _____ ☐ # of Years _____ ☐ or Year Quit _____

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Drugs:
Do you currently use recreational or street drugs? ☐ Yes ☐ No
Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Sex:
Are you sexually active? ☐ Yes ☐ No
If yes, are you trying for a pregnancy? ☐ Yes ☐ No
If not trying for a pregnancy list contraceptive or barrier method used? _____
Any discomfort with intercourse? ☐ Yes ☐ No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? ☐ Yes ☐ No

Personal Safety:
Do you live alone? ☐ Yes ☐ No
Do you have frequent falls? ☐ Yes ☐ No

Do you have vision or hearing loss? ..... ☐ Yes ☐ No
Do you have an Advance Directive and/or Living Will? ..... ☐ Yes ☐ No
Would you like information on the preparation of these? ..... ☐ Yes ☐ No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ..... ☐ Yes ☐ No

Please remember that the following recommendations are very important to maintaining your health.

When in a car, wear your safety belt at all times.

While riding a motorcycle or bicycle, wear a helmet.

Always have functional smoke detectors and fire extinguishers in your home.

If you own a firearm, make sure that it is accessible only to you. Take every precaution to ensure that children do not have access to a loaded firearm.

Keep the firearm and ammunition in separate locations.

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death
Father			
Mother			
Brothers and Sisters	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

	Age	Age at Death	Significant Health Problems or Cause of Death
Children	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
Grandparents (Mother's Side)			
Male			
Female			
Grandparents (Father's Side)			
Male			
Female			

Continued on Back Side

MENTAL HEALTH

Is stress a major problem for you? ..... ☐ Yes ☐ No
Do you feel depressed? ..... ☐ Yes ☐ No
Do you panic when stressed? ..... ☐ Yes ☐ No
Do you have problems with eating or your appetite? ..... ☐ Yes ☐ No
Do you cry frequently? ..... ☐ Yes ☐ No
Have you ever attempted suicide? ..... ☐ Yes ☐ No
Have you ever seriously thought about hurting yourself? ..... ☐ Yes ☐ No
Do you have trouble sleeping? ..... ☐ Yes ☐ No
Have you ever been to a counselor? ..... ☐ Yes ☐ No

WOMEN ONLY

Age at onset of menstruation: _____ Date of last menstruation: _____/_____/_____
Period every _____ days. Heavy periods, irregularity, spotting, pain or discharge? ..... ☐ Yes ☐ No
Number of pregnancies _____ Number of live births _____
Are you pregnant or breastfeeding? ..... ☐ Yes ☐ No
Have you had a D&C, hysterectomy or cesarean? ..... ☐ Yes ☐ No
Any urinary tract, bladder or kidney infections within the last year? ..... ☐ Yes ☐ No
Any blood in your urine? ..... ☐ Yes ☐ No
Any problems with control of urination? ..... ☐ Yes ☐ No
Any hot flashes or sweating at night? ..... ☐ Yes ☐ No
Do you have menstrual tension, pain, bloating,
irritability or other symptoms at or around time of period? ..... ☐ Yes ☐ No
Experienced any recent breast tenderness, lumps or nipple discharge? ..... ☐ Yes ☐ No
Date of last pap and rectal exam? _____/_____/_____

MEN ONLY

Do you usually get up to urinate during the night? ..... ☐ Yes ☐ No If yes, # of times _____
Do you feel pain or burning with urination? ..... ☐ Yes ☐ No
Any blood in your urine? ..... ☐ Yes ☐ No
Do you feel burning discharge from penis? ..... ☐ Yes ☐ No
Has the force of your urination decreased? ..... ☐ Yes ☐ No
Have you had any kidney, bladder or prostate infections within the last 12 months? ..... ☐ Yes ☐ No
Do you have any problems emptying your bladder completely? ..... ☐ Yes ☐ No
Any difficulty with erection or ejaculation? ..... ☐ Yes ☐ No
Any testicle pain or swelling? ..... ☐ Yes ☐ No
Date of last prostate and rectal exam? _____/_____/_____

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin_____
☐ Head/Neck _____
☐ Ears_____
☐ Nose _____
☐ Throat _____
☐ Lungs _____
☐ Chest/Heart_____

☐ Back _____
☐ Intestinal _____
☐ Bladder _____
☐ Bowel _____
☐ Circulation _____

Recent Changes In:

☐ Weight _____

☐ Energy Level _____
☐ Ability to Sleep_____

Other Pain/Discomfort:

_____
_____
_____
_____