Full Circle Medical Center

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HEALTH QUESTIONNAIRE

Note: Read carefully and fill out as completely as possible. The information provided by this Questionnaire will become a permanent part of your records at our Center.

IDENTIFICATION

NAME: ____ **AGE:** ______________

TODAY'S DATE: ____ /____ /_____ **DATE OF BIRTH:** ____ /____ /_____ **LAST 4 OF SS #:**____________

NAME OF PERSON WHO REFERRED YOU TO THIS CLINIC:

____

NAME OF PRIMARY CARE PHYSICIAN & OTHER PRACTICIONERS:

____

____

DATE OF LAST CONSULTATION WITH PRIMARY CARE PHYSICIAN: ______________________________

FEMALE ☐ **MALE** ☐ **HEIGHT** _______ FT. _______ **WEIGHT** ___________ LBS

RACE: American Indian ☐ Black ☐ Caucasian ☐ Spanish American ☐ Other__________________

MARITAL STATUS: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

NAME OF SPOUSE: __________________________________ **DATE OF BIRTH:** _____ /_____ / _____

PERMANENT HOME ADDRESS

STREET: ____ **PHONE:** (_______)_______________

CITY: _______________________________________ **STATE:** _______________ **ZIP:** _____________

COUNTY: ________________________ **CELL PHONE :** (_______)_________________

E-MAIL ADDRESS: ____

MAJOR COMPLAINTS AND HOW LONG THEY HAVE BEEN PRESENT:

i.e. HEART DISEASE X 10 YEARS OR KIDNEY DISEASE X 5 YEARS _______________________________________

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IN YOUR OWN WORDS DESCRIBE <u>YOUR MOST PERSISTENT MEDICAL PROBLEMS</u> WITH SYMPTOMS, THEIR DURATION AND RESPONSE TO PREVIOUS TREATMENTS: ____

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ILLNESS AND MEDICAL PROBLEMS

Check problems you have or have had that have been diagnosed or treated by a physician or other health professionals.

YES	NO	PROBLEM
☐	☐	Acne
☐	☐	Alcoholism
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Anemia – Sickle Cell
☐	☐	Appendicitis
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Back Strain
☐	☐	Bladder Infection—Cystitis
☐	☐	Bronchitis—Chronic
☐	☐	Cancer
		If yes, Location:__________________
☐	☐	Cirrhosis, Liver
☐	☐	Colitis, spastic or ulcerative
☐	☐	Concussion
☐	☐	Congenital defect
☐	☐	Depression
☐	☐	Diabetes
☐	☐	Diabetes, uncontrolled
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	**Glasses or Contacts**
☐	☐	Visual problem not correctable
☐	☐	Astigmatism
☐	☐	Nearsighted
☐	☐	Farsighted
☐	☐	Blindness, either eye
☐	☐	Cataract, either eye
☐	☐	Amblyopia, lazy eye
☐	☐	Glaucoma
☐	☐	Retinal detachment
☐	☐	Fibrocystic breasts
☐	☐	Gonorrhea
☐	☐	Gout
☐	☐	Hay Fever
☐	☐	Hearing loss—left ear
☐	☐	Hearing loss—right ear
☐	☐	High blood fats (check one)
		☐ Cholesterol ☐ Triglycerides
☐	☐	Heart Attack

YES	NO	PROBLEM
☐	☐	Coronary Disease
☐	☐	Rheumatic Heart Disease
☐	☐	Heart Murmur
☐	☐	Enlarged Heart
☐	☐	Heart rhythm problem
☐	☐	Other Heart problem (List)
		a) ____________________
		b) ____________________
☐	☐	Heart Catherization
☐	☐	Hepatitis
☐	☐	Herpes (fever blisters, shingles, genital)
☐	☐	High blood pressure
☐	☐	High blood pressure, uncontrolled
☐	☐	Hypoglycemia—low blood sugar
☐	☐	Infectious mononucleosis
☐	☐	Kidney infection—pyelonephritis
☐	☐	Kidney problem—other
☐	☐	Knee surgery
☐	☐	Mental Illness
☐	☐	Migraine headache
☐	☐	Neck Strain
☐	☐	Nervous stomach
☐	☐	Obesity—more than 20 lbs. overweight
☐	☐	Ovarian Cyst
☐	☐	Pelvic infection
☐	☐	Peptic Ulcer—gastric, duodenal
☐	☐	Phlebitis
☐	☐	Pneumonia
☐	☐	Polyps in colon
☐	☐	Prostate infection
☐	☐	Regional ileitis
☐	☐	Rheumatic fever
☐	☐	Rheumatoid arthritis
☐	☐	Sinus trouble, chronic
☐	☐	Serious injury with permanent damage
☐	☐	Stroke
☐	☐	Suicide attempt
☐	☐	Syphilis
☐	☐	Thyroid—overactive
☐	☐	Thyroid—underactive
☐	☐	Tension headaches
☐	☐	Tuberculosis
☐	☐	Vaginitis, chronic
☐	☐	Other problem not listed

DISABILITY

A disability is a medical problem that causes long term impairment of your ability to work or function.

YES	NO	PROBLEM
☐	☐	Do you have a medical DISABILITY?

If yes, specify:________________________________
____

Specify needs, functional status for disability.

YES	NO	PROBLEM
☐	☐	Wheelchair
☐	☐	Require special housing
☐	☐	Uses crutches
☐	☐	Sports activity restricted

Do you have loss or seriously limited function of any of the organs listed below?

YES	NO	ORGAN			
☐	☐	Eyes	☐	☐	Ears
☐	☐	Bowels	☐	☐	Kidneys
☐	☐	Arms or legs	☐	☐	Other

ALLERGIES

An allergy is a skin rash, hives, joint pain or swelling, or fever after exposure to a desensitizing agent.

YES	NO	
☐	☐	Have you ever undergone allergy testing?

If yes, when: __________________________

Are you allergic to:

YES	NO	
☐	☐	Aspirin
☐	☐	Bee stings
☐	☐	Certain animals
☐	☐	Food

If yes, which ones:______________________

YES	NO	
☐	☐	Dust
☐	☐	Eggs
☐	☐	Grasses
☐	☐	Molds, fungi
☐	☐	Penicillin
☐	☐	Poison Ivy
☐	☐	Pollens, ragweed
☐	☐	Sulfa
☐	☐	Tetanus Toxoid
☐	☐	X-Ray media
☐	☐	Drug Allergies

If yes, which one:_____________________

MEDICATIONS

YES	NO	
☐	☐	Do you take any MEDICINE regularly or Frequently?

YES	NO	FOR	NAME AND DOSAGE
☐	☐	Antacid	
☐	☐	Antibiotic	
☐	☐	Antidepressant	
☐	☐	Antihistamines	
☐	☐	Allergy shots	
☐	☐	Arthritis medicine	
☐	☐	Aspirin	
☐	☐	Asthma medicine	
☐	☐	Barbiturate	
☐	☐	Blood thinner	
☐	☐	Blood vessel dilator	
☐	☐	Birth control pill	
☐	☐	Coronary heart med.	
☐	☐	Cough medicine	
☐	☐	Diabetic pill	
☐	☐	Diet pill	
☐	☐	Digitalis	
☐	☐	Diuretic	
☐	☐	Epilepsy, seizure med.	
☐	☐	Estrogen-hormone	
☐	☐	Headache medicine	
☐	☐	Heart rhythm med.	
☐	☐	High blood pressure med.	
☐	☐	Insulin	
☐	☐	Iron	
☐	☐	Laxative	
☐	☐	Muscle relaxant	
☐	☐	Nasal spray	
☐	☐	Nitroglycerin	
☐	☐	Nerve medicine	
☐	☐	Pain medicine	
☐	☐	Penicillin	
☐	☐	Potassium supplement	
☐	☐	Rheumatic heart med.	
☐	☐	Sleeping pills	
☐	☐	Stomach medicine	
☐	☐	Sulfa	
☐	☐	Tetracycline	
☐	☐	Thyroid hormone	
☐	☐	Vitamin supplements	
☐	☐	Tranquilizer	
☐	☐	Vitamin supplements	

HOSPITALIZATIONS

YES	NO	
☐	☐	Have you had any hospitalizations?

If yes, why and when? ______________________________

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OPERATIONS

YES	NO	
☐	☐	Have you had any operations?

	Year			Year	
☐		Appendix	☐		Hemorrhoids
☐		Back	☐		Hernia
☐		Bone	☐		Hysterectomy
☐		Brain	☐		Joint
☐		Breast	☐		Kidney
☐		Colon	☐		Lung
☐		C Section	☐		Neck
☐		Cystoscopy	☐		Stomach
☐		D and C	☐		Testicle
☐		Ears	☐		Thyroid
☐		Eyes	☐		Tonsils
☐		Gallbladder	☐		Tubal Ligation
☐		Heart	☐		Other

Specialist Recommended by your family M.D.

Drs. Name & Specialty: ______________________________

Specialist Diagnosis: ______________________________

Specialist Recommendations: ______________________________

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Did you comply with recommendations?

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FAMILY MEDICAL HISTORY

Check items that apply for your **blood relatives**. Your blood relatives include your children, brothers, sisters, parents and grandparents.

☐ I do not know my family history.

Yes	No	Illness	Relationship
☐	☐	Alcoholism	
☐	☐	Anemia-Sickle cell	
☐	☐	Anemia-Other	
☐	☐	Bleeding Trait	
☐	☐	Cancer	
☐	☐	Diabetes	
☐	☐	Epilepsy	
☐	☐	Heart Disease	
☐	☐	High blood pressure	
☐	☐	Hyperlipidemia	
☐	☐	High blood fats	
☐	☐	Mental illness	
☐	☐	Obesity	
☐	☐	Peptic ulcer	
☐	☐	Polycystic kidney	
☐	☐	Rheumatoid arthritis	
☐	☐	Stroke	
☐	☐	Suicide	
☐	☐	Thyroid overactive	
☐	☐	Thyroid underactive	
☐	☐	Tuberculosis	
☐	☐	Ulcerative cells	
☐	☐	Other	

☐	☐	Are you a twin?
☐	☐	Father died of heart attack before age 60?
☐	☐	Mother died of heart attack before age 60?
☐	☐	Sibling died of heart attack before age 60?
☐	☐	Mother or sister had cancer of the breast?
☐	☐	Did your mother take DES when she was pregnant with you?

Alive Yes	Alive No		Age or Age at Death	Health at Present or Cause of Death
☐	☐	Mother		
☐	☐	Father		
☐	☐	Brother(s)		
☐	☐			
☐	☐			
☐	☐	Sister(s)		
☐	☐			
☐	☐			

REVIEW OF SYSTEMS: These items concern either existing conditions or symptoms that occurred **WITHIN THE LAST YEAR.** They represent the detail that health professionals seek in evaluating a person's current or potential health problems. Do not fill in lines at bottom of sections.

HEAD

Yes	No	**In the past year,** have you had-
☐	☐	Staggering or balance problems?
☐	☐	Lightheadedness or standing up?
☐	☐	Spinning sensation or dizziness?
☐	☐	Fainting spells/Blackout spells?
☐	☐	Convulsions or seizures?
☐	☐	Muscular twitching?
☐	☐	Memory problem?
☐	☐	Difficulty with coordination?
☐	☐	Numbness or tingling in arms or legs?
☐	☐	Popping sensation when opening mouth?
☐	☐	Frequent or severe headaches?
☐	☐	Head injury or concussion requiring hospitalization?

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EYES

Yes	No	**In the past year,** have you had-
☐	☐	Persistent pain in either eye?
☐	☐	Puffiness or dark circles under your eyes?
☐	☐	Persistent watering or itching eyes?
☐	☐	Red, sore eyelids?
☐	☐	Double vision?
☐	☐	Problem of seeing halos around lights?
☐	☐	Blurry vision?
☐	☐	Sensitivity to lights?
☐	☐	Partial or full loss of vision?
☐	☐	Cataract or cataract surgery?
☐	☐	Glaucoma?
		Date of last eye examination?____________

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EARS, NOSE AND THROAT

Yes	No	**In the past year,** have you had-
☐	☐	Hearing difficulties or loss of hearing?
☐	☐	Buzzing or ringing in ears?
☐	☐	Frequent headaches?
☐	☐	Sinus trouble with stuffy nose, headache?

EARS, NOSE AND THROAT (CON'T)

Yes	No	
☐	☐	Frequent postnasal drip, tickle in throat?
☐	☐	Nosebleeds not due to injury?
☐	☐	Frequent sore throats?
☐	☐	Persistent or frequent hoarseness?
☐	☐	Persistent sore tongue?
☐	☐	Bleeding or sore gums?
☐	☐	Decreased sense of taste or smell?
☐	☐	Swollen glands in neck?

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RESPIRATORY

Yes	No	**In the past year,** have you had-
☐	☐	Frequent or persistent wheezing?
☐	☐	Frequent or persistent cough?
☐	☐	Frequent or severe SHORTNESS OF BREATH?
		If yes for shortness of breath, describe:
☐	☐	Present for years?
☐	☐	Began recently?
☐	☐	Worse with exercise?
☐	☐	Present at rest?
☐	☐	Relieved by resting?
☐	☐	Occurs with chest pains?
☐	☐	Occurs with wheezing?
☐	☐	Occurs with coughing?
☐	☐	Interferes with work or daily activities?
☐	☐	Recurrent bronchitis?
☐	☐	Pneumonia
☐	☐	Do you smoke?
☐	☐	Have you ever coughed up blood?
		Date of last chest x-ray? _________________
☐	☐	Positive or reactive T.B. test?

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CARDIOVASCULAR

Yes	No	**In the past year,** have you had-
☐	☐	Shortness of breath when lying down?
☐	☐	Using more than one pillow to sleep?
☐	☐	Fluid retention with swelling of feet or legs?
☐	☐	Episodic pain, whiteness of hands or feet?
☐	☐	Calf pain when walking, relieved by rest?
☐	☐	Irregular heartbeat, skipped beats?
☐	☐	Bouts of heartbeat so fast you can't count?
☐	☐	Pain, pressure, or tight feeling in chest which forced you to stop walking?
☐	☐	Frequent or severe CHEST PAIN?

If yes for chest pain, describe:

Yes	No	
☐	☐	Present at rest?
☐	☐	Worse with exercise?
☐	☐	Worse with deep breathing?
☐	☐	Worse with nervousness?
☐	☐	Relieved by resting?
☐	☐	Relieved with Nitroglycerin?
☐	☐	Relieved by Antacids?

Date of last visit with cardiologist? _________

Date of last electrocardiogram? ___________

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URINARY

Yes	No	**In the past year,** have you had-
☐	☐	Loss of urine control?
☐	☐	Awaken from sleep to urinate?
☐	☐	Urinate more than 10 times a day?
☐	☐	Frequent pain or burning with urination?
☐	☐	Blood in urine?
☐	☐	Pain in flank accompanied by fever?
☐	☐	Abdominal pain with urination?
☐	☐	Trouble getting urine started?
☐	☐	Bedwetting problems?

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DIGESTIVE

Yes	No	**In the past year,** have you had-
☐	☐	Frequent nausea or vomiting?
☐	☐	Vomiting of bright red blood?
☐	☐	Vomiting of "coffee grounds" material?
☐	☐	Difficulty swallowing?
☐	☐	Hot burning fluid in throat or chest?
☐	☐	Black tarry stools?
☐	☐	Frequent diarrhea or watery stools?
☐	☐	Frequent constipation?
☐	☐	Unexplained rectal bleeding?
☐	☐	Frequent or severe heartburn or indigestion?
☐	☐	Frequent or severe ABDOMINAL PAIN?

If yes for abdominal pain, describe:

Yes	No	
☐	☐	Upper abdomen
☐	☐	Lower abdomen
☐	☐	Right side
☐	☐	Left side
☐	☐	Dull ache
☐	☐	Cramping
☐	☐	Sharp, knife-life
☐	☐	Burning

Abdominal pain accompanied by:

Yes	No	
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Nausea
☐	☐	Menstrual periods
☐	☐	Gas in belly after meals
☐	☐	Frequent belching

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MEN (WOMEN GO TO NEXT SECTION)

Yes	No	**In the past year,** have you had-
☐	☐	Enlarged or infected prostate?
☐	☐	Pus or drainage from penis?
☐	☐	Rupture or swelling in groin?
☐	☐	Nodule in testicle growing larger?
☐	☐	Problem with sexual function?
☐	☐	Pain or tenderness in groin?

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WOMEN (MEN GO TO NEXT SECTION)

Yes	No	Have you ever-
☐	☐	Had a period?
		Date of last period: ____________________
		Age of onset of period: _________________
☐	☐	Been pregnant?
		# of pregnancies: ______________________
		# of live births:________________________
		Weight of live births: ___________________
		# of miscarriages:______________________
		Complications of pregnancies: ___________ ____________________________________
☐	☐	Been on birth control pills?
☐	☐	Had hard lumps or cysts in breasts?
☐	☐	Do you have routine annual breast exams?
☐	☐	Excessive pain, bleeding with periods?
☐	☐	Irregular periods?
		Date of last pelvic and pap smear:_________
☐	☐	Bleeding or spotting between periods?
☐	☐	Vaginal bleeding after menopause?
		Age at time of menopause: ______________
☐	☐	Persistent vaginal itching or dryness?
☐	☐	Treatment for vaginal infection or discharge?
☐	☐	Problem with sexual dysfunction?

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MUSCULOSKELETAL

Yes	No	**In the past year,** have you had-
☐	☐	Frequent or severe neck or back pain?
☐	☐	Muscle weakness or fatigue?
☐	☐	Pain or stiffness in joints?
☐	☐	Muscle or tendon problems due to sports?
☐	☐	Persistent JOINT PAIN NOT due to injury?

If yes for joint pain NOT due to injury, describe:

Yes	No	
☐	☐	Swelling?
☐	☐	Hot feeling?
☐	☐	Redness
☐	☐	Stiffness?
☐	☐	Painful feet?

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NEUROLOGICAL

Yes	No	**In the past year,** have you had-
☐	☐	Numbness?
☐	☐	Convulsions or seizures?
☐	☐	Trembling episodes?
☐	☐	Periods of unconsciousness?
☐	☐	Stroke?
☐	☐	Loss of feeling or sensation over any part of your body?

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VASCULAR

Yes	No	**In the past year,** have you had-
☐	☐	Varicose veins?
☐	☐	Phlebitis?
☐	☐	Easy bruising?
☐	☐	Easy bleeding?
☐	☐	Ulcers on lower extremities?
☐	☐	Cold, numb or tingling extremities?
☐	☐	Leg or calf cramps at night?
☐	☐	Coronary artery disease?

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SKIN

Yes	No	**In the past year,** have you had-
☐	☐	Itching or burning skin?
☐	☐	Discolored moles or warts?
☐	☐	Loss of large amounts of hair?
☐	☐	Skin lesions/skin cancers?
☐	☐	Dry skin or brittle nails?
☐	☐	Scaling of skin of lower extremities?
☐	☐	Discoloration of skin?
☐	☐	Skin or whites of eyes turning yellow?
☐	☐	Persistent rash or pimples?
☐	☐	Eczema/ psoriasis

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ENDOCRINE

Yes	No	**In the past year,** have you had-
☐	☐	Weight gain or loss?
☐	☐	Frequent or constant thirst?
☐	☐	Poor wound healing?
☐	☐	Hypo (low) thyroidism?
☐	☐	Hyper (high) thyroidism?
☐	☐	Hot flashes?
☐	☐	Temperature intolerances?
☐	☐	Constant fatigue?
☐	☐	Congenital abnormalities?
☐	☐	Sweating episodes at night?

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EMOTIONAL

Yes	No	**In the past year,** have you had-
☐	☐	Loneliness?
☐	☐	Depression?
☐	☐	Lack of concentration or memory?
☐	☐	Crying spells?
☐	☐	Considered suicide?
☐	☐	Sleeping difficulties?
☐	☐	Excessive nervousness?
☐	☐	Still tired after full night's sleep?
☐	☐	Difficulty relaxing?
☐	☐	Psychological/Psychiatric counseling?

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GENERAL

Yes	No	**In the past year,** have you had-
☐	☐	Pollen allergies?
☐	☐	Food allergies?
☐	☐	Drug allergies?
☐	☐	Reaction to drugs, serum or other medication?
☐	☐	Frequent colds or flu like syndromes?

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CHILDREN ONLY

The following questions pertain specifically to children. This information will help us to ascertain an overall picture of the child's medical problems.

Yes	No	**Does the child have-**
☐	☐	Chronic runny nose?
☐	☐	Chronic red, itchy eyes?
☐	☐	Purulent drainage from eyes or ears?
☐	☐	Chronic sneezing spells?
☐	☐	Recurrent episodes of areas of patchy, dry scaly skin?
☐	☐	Whining episodes?
☐	☐	Sudden changes in temperature?
☐	☐	Spells of intense temper with fury?
☐	☐	Few friends?
☐	☐	Problems being shy/timid?
☐	☐	Crying spells without reason?
☐	☐	Difficulty learning simple tasks?
☐	☐	Writing problems?
☐	☐	Reading problems?
☐	☐	Speaking problems or stuttering?
☐	☐	Problems in school?
☐	☐	Disciplinary problems?
☐	☐	Problems gaining weight?
☐	☐	Finicky/picky eating habits?
☐	☐	Periods of fatigue/lethargy?
☐	☐	Night sweats?
☐	☐	Problems with bedwetting?
☐	☐	Problems with bowel/urine incontinence?
☐	☐	Problems with frequent diarrhea or constipation?
☐	☐	Episodes of hyperactivity?
☐	☐	Sleeping problems/nightmares?
☐	☐	Problems with sluggishness in the morning?

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