



SPRING CHICKEN  
— FAMILY HEALTH —

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## PATIENT INTAKE QUESTIONNAIRE

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

<b>Name</b> <small>(Last, First, M.I.):</small>		<b>Today's Date</b>	
<b>Address</b> <small>(Street.):</small>		<b>Date of Birth</b>	
<small>(City, State, Zip.):</small>		<b>Occupation</b>	
<b>Email</b>		<b>Employer</b>	
<b>Phone</b>	H:	M:	W:
<b>Marital status:</b>	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
<b>Children</b> <small>(Names, Ages)</small>			
<b>Previous or referring doctor:</b>		<b>Date of last physical exam:</b>	
<b>How did you hear about me?</b>			
<b>CHIEF COMPLAINT</b>			
<b>What is the primary health concern or goal that brings you to the clinic?</b>			
<b>Brief History of Chief Complaint</b> <small>(when it started, what makes it better/worse, severity, etc)</small>			
<b>List other health issues you hope to address</b>			

**PERSONAL HEALTH HISTORY**

**List any other 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

**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**

Name the Drug	Strength	Frequency Taken

**Allergies**

Name the Drug	Reaction You Had
Any Other Allergies	

## HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

<b>Exercise</b>	Describe exercise activities: the frequency, intensity, time and type of activity. For example (twice weekly beginner 1 hour yoga classes)				
<b>Activities</b>	Describe your interests, hobbies, spiritual practices, things you do to relax				
<b>Diet</b>	Are you dieting?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	# of meals you eat in an average day?				
	What Have you eaten in the last 24 hours?				
	If the above dietary recall is atypical for you, describe a typical day here.				
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	Number of cups/cans per day?				
<b>Alcohol</b>	Do you drink alcohol?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Have you considered stopping?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Have you ever experienced blackouts?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Are you prone to "binge" drinking?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Do you drive after drinking?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<b>Tobacco</b>	Do you use tobacco?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	<input type="checkbox"/> Cigarettes – pks./day:	<input type="checkbox"/> Chew - #/day:	<input type="checkbox"/> Pipe - #/day:	<input type="checkbox"/> Cigars - #/day:	
	<input type="checkbox"/> # of years:	<input type="checkbox"/> Or year quit:			

<b>Drugs</b>	Do you currently use recreational or street drugs?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<b>Sex</b>	Are you sexually active?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<b>Personal Safety</b>	Do you live alone	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Do you have traction stickers or bathtub mat?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Do you have a fire extinguisher?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Do you have frequent falls?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Do you have vision or hearing loss?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Do you wear a seatbelt?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

### FAMILY HEALTH HISTORY

*FOR DECEASED RELATIVES MARK A LETTER "D" AND THEIR AGE AT DEATH, SPECIFY CAUSE OF DEATH IF KNOWN*

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M	
			<input type="checkbox"/> F		
<b>Sibling(s)</b>	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<b>Grandmother</b> <i>Maternal</i>		
	<input type="checkbox"/> F				
	<input type="checkbox"/> M		<b>Grandfather</b> <i>Maternal</i>		
	<input type="checkbox"/> F				
	<input type="checkbox"/> M		<b>Grandmother</b> <i>Paternal</i>		
	<input type="checkbox"/> F				
	<input type="checkbox"/> M		<b>Grandfather</b> <i>Paternal</i>		
	<input type="checkbox"/> F				

**WOMEN ONLY**

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

**MEN ONLY**

Do you usually get up to urinate during the night?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If yes, # of times:				
Do you feel pain or burning with urination?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any blood in your urine?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you feel burning discharge from penis?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Has the force of your urination decreased?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any difficulty with erection or ejaculation?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any testicle pain or swelling?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

