Medical History Questionnaire

Name: _____ **Birthday:** _____

****Are You Having Chest Pains Or Shortness Of Breath?** ☐ Yes ☐ No **If Yes, Please Notify Staff.**

Allergies:

_____

Medical Conditions:

_____

_____

Surgeries:

_____

List All Medications and Dosages:

_____

_____

Are You Pregnant? ☐ Yes ☐ No **Are You Nursing?** ☐ Yes ☐ No

Family Medical History			
		Relationship	**Maternal (M) or Paternal (P)**
Alcoholism	Yes / No	_____	M / P
Asthma	Yes / No	_____	M / P
Bleeding Disorders	Yes / No	_____	M / P
Cancer	Yes / No	_____	M / P
Diabetes	Yes / No	_____	M / P
Epilepsy/Convulsions	Yes / No	_____	M / P
Glaucoma	Yes / No	_____	M / P
Heart Disease	Yes / No	_____	M / P
High Blood Pressure	Yes / No	_____	M / P
Kidney Disease	Yes / No	_____	M / P
Mental Illness	Yes / No	_____	M / P
Osteoporosis	Yes / No	_____	M / P
Stroke	Yes / No	_____	M / P
Thyroid Disease	Yes / No	_____	M / P
Other Disease/Condition:			
_____			
_____			

Social History			
Have You Ever Been Exposed To Or Infected With:			
Gonorrhea:	Yes / No	Syphilis:	Yes / No
Hepatitis:	Yes / No	HIV/AIDS:	Yes / No
Do You Use Any Of The Following?			
Alcohol:	Yes / No	Drugs:	Yes / No
Smoke:	Yes / No		
- Current Use: Pack/Day _____ # Of Years _____			
- If You Quit, How Long Ago? _____			
Coffee:	Yes / No	Cups/Day _____	
Tea:	Yes / No	Glasses/Day _____	
Cola:	Yes / No	Cans/Day _____	
Screenings			
Last Mammogram/ Pap: _____			
Last Colonoscopy: _____			
Last Colorectal Screening: _____			
Reason For Visit:			
_____			
_____			

Review Systems					
Eyes		Constipation	Yes / No	***Musculoskeletal***	
Blurred Vision	Yes / No	***Integumentary/Skin***		Back Pain	Yes / No
Double Vision	Yes / No	Rash	Yes / No	Arthritis	Yes / No
Frequent Eye Infections	Yes / No	Itching	Yes / No	Gout	Yes / No
Ears, Nose, Throat, Mouth		Hives	Yes / No	***Genitourinary***	
Frequent Ear Infections	Yes / No	***Neurological***		Frequent Urination	Yes / No
Sinus Infection	Yes / No	Seizures	Yes / No	Blood in Urine	Yes / No
Hay Fever/Allergies	Yes / No	Frequent Headaches	Yes / No	Painful Urination	Yes / No
Nose Bleeds	Yes / No	Stroke	Yes / No	Frequent Urinary Infections	Yes / No
Frequent Sore Throat	Yes / No	Fainting Spells	Yes / No	***Hematologic/Lymphatic***	
Gastrointestinal		***Psychiatric***		Anemia	Yes / No
Frequent Nausea/Vomiting	Yes / No	Depression	Yes / No	Bruise Easily	Yes / No
Change in Bowel Habits	Yes / No	Frequent Crying	Yes / No	Chronic Fatigue	Yes / No
Blood in Stools	Yes / No	Nervousness	Yes / No	***Immunologic/Allergy***	
Black Stools	Yes / No	Moodiness	Yes / No	Cancer	Yes / No
Indigestion	Yes / No	***Endocrine***		Tuberculosis	Yes / No
Loss of Appetite	Yes / No	Diabetes	Yes / No	Frequent and/or Persistent	
Diarrhea	Yes / No	Thyroid Disorders	Yes / No	Infections or Illness	Yes / No

NeoHealth
NORTHEASTERN OKLAHOMA COMMUNITY HEALTH CENTERS, INC.

PHQ9P

Patient Health Questionnaire - 9

This section for use by study personnel only.

Was data collected? **No** ☐ *(provide reason in comments)*

If yes, data collected on visit date ☐ **or** specify date: _____
DD-Mon-YYYY

Comments:

Only the patient (subject) should enter information onto this questionnaire.

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	**0**	**1**	**2**	**3**
2. Feeling down, depressed, or hopeless.	**0**	**1**	**2**	**3**
3. Trouble falling or staying asleep, or sleeping too much.	**0**	**1**	**2**	**3**
4. Feeling tired or having little energy.	**0**	**1**	**2**	**3**
5. Poor appetite or overeating.	**0**	**1**	**2**	**3**
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	**0**	**1**	**2**	**3**
7. Trouble concentrating on things, such as reading the newspaper or watching television.	**0**	**1**	**2**	**3**
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	**0**	**1**	**2**	**3**
9. Thoughts that you would be better off dead or hurting yourself in some way.	**0**	**1**	**2**	**3**
	Scoring For Use By Study Personnel Only **0** + _____ + _____ + _____ **= Total Score:** _____			

If you check off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐	**Somewhat difficult** ☐	**Very difficult** ☐	**Extremely difficult** ☐

I confirm this information is accurate.	Patient's/Subject's initials:	Date: