

Two Rivers Family Practice

1231 South Patrick Drive, Satellite Beach, FL 32937

Medical Health History Questionnaire

Information provided on this form will assist your health care provider to better understand your medical conditions and concerns. All questions are optional and will be kept confidential.

Patient Name: _____ DOB: _____ Today's Date: _____

ALLERGIES

NO KNOWN ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how they affect you.

ALLERGY	REACTION
1	
2	
3	

MEDICATIONS

PLEASE LIST ALL PRESCRIBED DRUGS AND OVER THE COUNTER DRUGS SUCH AS VITAMINS AND INHALERS

DRUG NAME	STRENGTH	FREQUENCY TAKEN	REFILLS NEEDED
1			<input type="checkbox"/> YES <input type="checkbox"/> No
2			<input type="checkbox"/> YES <input type="checkbox"/> No
3			<input type="checkbox"/> YES <input type="checkbox"/> No
4			<input type="checkbox"/> YES <input type="checkbox"/> No
5			<input type="checkbox"/> YES <input type="checkbox"/> No
6			<input type="checkbox"/> YES <input type="checkbox"/> No
7			<input type="checkbox"/> YES <input type="checkbox"/> No
8			<input type="checkbox"/> YES <input type="checkbox"/> No
9			<input type="checkbox"/> YES <input type="checkbox"/> No
10			<input type="checkbox"/> YES <input type="checkbox"/> No
11			<input type="checkbox"/> YES <input type="checkbox"/> No
12			<input type="checkbox"/> YES <input type="checkbox"/> No
13			<input type="checkbox"/> YES <input type="checkbox"/> No
14			<input type="checkbox"/> YES <input type="checkbox"/> No
15			<input type="checkbox"/> YES <input type="checkbox"/> No

Immunization History

Flu Shot	Date: _____	Measles/Mumps/Rubella(MMR)	Date: _____
Tetanus/Diphtheria/Pertussis (DPT)	Date: _____	Pneumonia Vaccine	Date: _____
Chickenpox	Date: _____	Human Papillomavirus (HPV)	Date: _____
Meningitis Vaccine	Date: _____	Td or Tdap	Date: _____
Hepatitis A (2 shot series)	Date(s): _____	COVID Vaccine	Date(s): _____
Hepatitis B (3 shot series)	Date(s): _____	Shingles	Date: _____

Past Medical History (please check all that apply)

<input type="checkbox"/> GERD/Heartburn	<input type="checkbox"/> Congestive Heart Failure (CHF)	<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Dementia/Alzheimer's
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Asthma
<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> AICD(Defibrillator)	<input type="checkbox"/> Difficulty Sleeping
<input type="checkbox"/> Hernia	<input type="checkbox"/> COPD	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Depression
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> TIA/Stroke	<input type="checkbox"/> Anemia
<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Other: _____
<input type="checkbox"/> High Blood Pressure (HTN)	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Coronary Artery Disease (CAD)	<input type="checkbox"/> DVT/Blood Clot	
<input type="checkbox"/> Cardiac Stent	<input type="checkbox"/> Cancer (Type: _____)	
<input type="checkbox"/> Bladder or Kidney Issues	<input type="checkbox"/> Dialysis	
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Heart Attack	
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Measles/Mumps/Chickenpox/Polio	<input type="checkbox"/> Back pain	
<input type="checkbox"/> Rubella	<input type="checkbox"/> Headaches/Migraines	
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Parkinson's Disease	
<input type="checkbox"/> Abnormal Vaginal Bleeding	<input type="checkbox"/> Recurrent Urinary Tract Infections (UTI)	

Men Only: (if applicable)

Date of last PSA (lab test) _____ Last Prostate Exam: _____

Pain or lump in testicles YES No Prostate problems YES No

Straining with urination YES No Sexual Difficulties YES No

Women Only: Obstetric and Gynecological History (if applicable)

Age at first Menstrual Cycle _____ Date of last menstrual cycle: _____

Date of last Pap Smear _____ Normal Abnormal Date of last DEXA Scan: _____

Date of last mammogram: _____ Normal Abnormal Abnormal vaginal bleeding YES No

Pelvic Pain YES No Sexual difficulties YES No

of pregnancies__ live births__ miscarriages__ Age at First Child Birth _____

If Post-Menopausal, Age at Menopause _____ Post-Menopausal Bleeding YES No

Breast Augmentation YES No Breast Reduction YES No

Mastectomy YES No Hysterectomy YES No

Tubal Ligation YES No Cesarean Section YES No

Men and Women: (if applicable)

Date of Last Colonoscopy Date:_____ Location:_____ GI Doctor:_____ Normal Abnormal

Please list all Specialists who are involved with your care:

(If none skip to next)

Surgical History

	<u>Date/Year</u>		<u>Date/Year</u>
EGD (Upper Endoscopy)	<input type="checkbox"/> _____	Prostate Surgery	<input type="checkbox"/> _____
Ulcer Surgery	<input type="checkbox"/> _____	Back Surgery	<input type="checkbox"/> _____
Colon Surgery	<input type="checkbox"/> _____	Hip Surgery (R)(L)	<input type="checkbox"/> _____
Gallbladder Surgery	<input type="checkbox"/> _____	Knee Surgery (R)(L)	<input type="checkbox"/> _____
Appendectomy	<input type="checkbox"/> _____	Weight Loss Surgery	<input type="checkbox"/> _____
Hemorrhoidectomy	<input type="checkbox"/> _____	Heart Bypass Surgery	<input type="checkbox"/> _____
Heart Valve Replacement	<input type="checkbox"/> _____	Hysterectomy	<input type="checkbox"/> _____
Ovaries Removed (R)(L)	<input type="checkbox"/> _____	(partial/complete)	

Other Surgeries: _____

Patient Health Questionnaire-2 (PHQ-2)

Little interest or pleasure in doing things? Not at all Several Days More than half the days Nearly every day
Feeling down, depressed, or hopeless? Not at all Several Days More than half the days Nearly every day

Family History (Please CHECK ALL that apply for each family member)

Maternal Grandmother	<input type="checkbox"/> Alive (Age:_____)	<input type="checkbox"/> Deceased (Age:_____)	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Peripheral Vascular Disease
	<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Depression	
	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> Stroke	<input type="checkbox"/> COPD	<input type="checkbox"/> Autism
	<input type="checkbox"/> COPD	<input type="checkbox"/> Autism	
	<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Disorder of Thyroid Gland
	<input type="checkbox"/> Obesity	<input type="checkbox"/> Osteoporosis	
	<input type="checkbox"/> Cancer	If yes, what type: _____	(Colon, Breast, etc)
Maternal Grandfather	<input type="checkbox"/> Alive (Age:_____)	<input type="checkbox"/> Deceased (Age:_____)	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Peripheral Vascular Disease
	<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Depression	
	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> Stroke	<input type="checkbox"/> COPD	<input type="checkbox"/> Autism
	<input type="checkbox"/> COPD	<input type="checkbox"/> Autism	
	<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Disorder of Thyroid Gland
	<input type="checkbox"/> Obesity	<input type="checkbox"/> Osteoporosis	
	<input type="checkbox"/> Cancer	If yes, what type: _____	(Colon, Breast, etc)

Paternal Grandmother	<input type="checkbox"/> Alive (Age:____)	<input type="checkbox"/> Deceased (Age:____)	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Depression		
	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Diabetes <input type="checkbox"/> Stroke <input type="checkbox"/> COPD <input type="checkbox"/> Autism		
	<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Disorder of Thyroid Gland <input type="checkbox"/> Obesity <input type="checkbox"/> Osteoporosis		
	<input type="checkbox"/> Cancer If yes, what type: _____ (Colon, Breast, etc)		
Paternal Grandfather	<input type="checkbox"/> Alive (Age:____)	<input type="checkbox"/> Deceased (Age:____)	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Depression		
	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Diabetes <input type="checkbox"/> Stroke <input type="checkbox"/> COPD <input type="checkbox"/> Autism		
	<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Disorder of Thyroid Gland <input type="checkbox"/> Obesity <input type="checkbox"/> Osteoporosis		
	<input type="checkbox"/> Cancer If yes, what type: _____ (Colon, Breast, etc)		
Mother	<input type="checkbox"/> Alive (Age:____)	<input type="checkbox"/> Deceased (Age:____)	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Depression		
	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Diabetes <input type="checkbox"/> Stroke <input type="checkbox"/> COPD <input type="checkbox"/> Autism		
	<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Disorder of Thyroid Gland <input type="checkbox"/> Obesity <input type="checkbox"/> Osteoporosis		
	<input type="checkbox"/> Cancer If yes, what type: _____ (Colon, Breast, etc)		
Father	<input type="checkbox"/> Alive (Age:____)	<input type="checkbox"/> Deceased (Age:____)	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Depression		
	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Diabetes <input type="checkbox"/> Stroke <input type="checkbox"/> COPD <input type="checkbox"/> Autism		
	<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Disorder of Thyroid Gland <input type="checkbox"/> Obesity <input type="checkbox"/> Osteoporosis		
	<input type="checkbox"/> Cancer If yes, what type: _____ (Colon, Breast, etc)		
Brother/Sister	<input type="checkbox"/> Alive (Age:____)	<input type="checkbox"/> Deceased (Age:____)	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Depression		
	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Diabetes <input type="checkbox"/> Stroke <input type="checkbox"/> COPD <input type="checkbox"/> Autism		
	<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Disorder of Thyroid Gland <input type="checkbox"/> Obesity <input type="checkbox"/> Osteoporosis		
	<input type="checkbox"/> Cancer If yes, what type: _____ (Colon, Breast, etc)		
Brother Sister	<input type="checkbox"/> Alive (Age:____)	<input type="checkbox"/> Deceased (Age:____)	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Depression		
	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Diabetes <input type="checkbox"/> Stroke <input type="checkbox"/> COPD <input type="checkbox"/> Autism		
	<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Disorder of Thyroid Gland <input type="checkbox"/> Obesity <input type="checkbox"/> Osteoporosis		
	<input type="checkbox"/> Cancer If yes, what type: _____ (Colon, Breast, etc)		

Social History (Please CHECK All that Apply)

Marital Status:	<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Life Partner
	<input type="checkbox"/> Legally Separated				
Occupation:	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Retired	<input type="checkbox"/> Homemaker	<input type="checkbox"/> Student
	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Disabled			
Who Lives With You:	<input type="checkbox"/> Spouse	<input type="checkbox"/> Children	<input type="checkbox"/> Partner	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
	<input type="checkbox"/> No One	<input type="checkbox"/> Roommate			
Exercise:	<input type="checkbox"/> Never	<input type="checkbox"/> Daily	<input type="checkbox"/> 1-2 times per week	<input type="checkbox"/> 3-4 times per week	
Diet:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Physician prescribed diet		
Caffeine Use:	<input type="checkbox"/> None	<input type="checkbox"/> Daily	<input type="checkbox"/> 1-3 cups/drinks a day	<input type="checkbox"/> 4 + cups/drinks per day	

Tobacco Use:

<input type="checkbox"/> Current tobacco user				
Form:	<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Cigars	<input type="checkbox"/> Smokeless Tobacco	<input type="checkbox"/> Chew
Amount:	<input type="checkbox"/> ½ PPD	<input type="checkbox"/> 1 PPD	<input type="checkbox"/> 2 PPD	<input type="checkbox"/> More than 2 PPD
Duration:	<input type="checkbox"/> 0-5 years	<input type="checkbox"/> 6-10 Years	<input type="checkbox"/> 10-20 years	<input type="checkbox"/> 20+ years
<input type="checkbox"/> Previous tobacco user				
Form:	<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Cigars	<input type="checkbox"/> Smokeless Tobacco	<input type="checkbox"/> Chew
Amount:	<input type="checkbox"/> ½ PPD	<input type="checkbox"/> 1 PPD	<input type="checkbox"/> 2 PPD	<input type="checkbox"/> More than 2 PPD
Duration:	<input type="checkbox"/> 0-5 years	<input type="checkbox"/> 6-10 Years	<input type="checkbox"/> 10-20 years	<input type="checkbox"/> 20+ years

If you quit, what year did you quit? _____

Never a tobacco user

Are you exposed to "second-hand" smoke? YES No

Alcohol Use:	<input type="checkbox"/> Never	<input type="checkbox"/> Daily	<input type="checkbox"/> Social Drinker	<input type="checkbox"/> Trying to Quit	<input type="checkbox"/> Previously
		<input type="checkbox"/> Less than 12 drinks a month		<input type="checkbox"/> 1-12 drinks a month	
		<input type="checkbox"/> 4-15 drinks a week		<input type="checkbox"/> more than 2 drinks a day	

Medical Marijuana Use: YES No Prescriber: _____

Recreational Drug Use: Never Daily Trying to Quit Previously

Previous Primary Care Provider

Name of Provider: _____ Phone: _____

Address: _____ Fax: _____
