SPRINGHILL MEDICAL GROUP
HEALTH QUESTIONARIE – Medical History and Background Information

Patient's Name ______________________________ **Date** ________________

Please take a few moments to provide this important background information. It will become part of your medical record and will be treated in strict confidence.

Past Medical History: list major illness or conditions with ongoing follow up.

______________________________ ______________________________

______________________________ ______________________________

______________________________ Pregnancies _______ Births ______

______________________________ Living Children ________________

Past Surgical History : list operations and year

____

____

Allergies to Medications : ____

Medications that you are now taking, including dose and schedule:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Family History:

	Father	Mother	Siblings	Children	Other
Heart Disease					
High Blood Pressure					
Stroke					
Cancer					
Diabetes					
Kidney disease					
Asthma/COPD					
Thyroid disorder					
Mental Illness					

Social History: Marital Status _________ Who lives with you ? ___________________

Do you smoke ? _______ Do you drink alcohol ? _______ Do you use seatbelts ? _____

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Health Maintenance: If you've had these screening tests, indicate the date of most recent test:

Mammogram _______ Pap Smear _________ Cholesterol __________
Colonoscopy _______ Barium Enema ______ Chest Xray __________
Digital Rectal exam ______ PSA __________

Adult vaccinations: Tetanus ______ Pneumonia vaccine (pneumovax) ________
Flu Vaccine ______ Hepatitits B _____________

Review of Systems and Symptons : please check if you are having these symptoms:

General:	**Chest :**	**Abdomen:**
Weight change	Breast lump	Gallstones
Fevers	Breast pain	Hepatitis
Chills	Nipple discharge	Diverticulosis
Night Sweats	Chest Pain	Change in appetite
Swelling	Angina	Swallowing problem
Rash	Heart Murmur	Heart Burn
Headache	Irregular Heart Beat	Abdominal pain
Migraine	Chest Tightness	Nausea/vomiting
Head/Neck:	Shortness of Breath	Diarrhea
Head injury	Wheezing	Constipation
Dizzy spells	Cough	Vomiting blood
Hearing changes	Sputum/phlegm	Bloody stools
Ringing in Ears	Bloody sputum	Hemorrhoids
Vision change	Asthma	Black Stools
Double vision	Emphysema	Hemorrhoids
Blind spots	Heart Attack	Ulcer
Nose Bleeds	Hypertension	**Genital /Urinary**:
Sinus Trouble	Rheumatic fever	Frequent urination
Sore Throat	**Neurologic:**	Painful urination
Hoarseness	Stroke	Night time urination
Neck Swelling	Seizure	Difficult to urinate
Thyroid Problems	Weakness	Blood in urine
Snoring	Memory Loss	Incontinence
	Sleep problems	Bladder infections
	Daytime sleepiness	Kidney stones
		Prostate problems

End of Life Planning:

Have you appointed a "Durable Power of Attorney for Health Care " ? ___________
Have you completed an "Advanced Directive"? _______________
Do you want more information about End of Life planning ? _______ yes _____ no