SPRINGHILL MEDICAL GROUP
HEALTH QUESTIONARIE – Medical History and Background Information

Patient's Name _____ **DOB:** _____ **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.

_____ _____

_____ _____

_____ 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 _____ PSA _____
Adult vaccinations: Tetanus _____ Pneumonia vaccine (pneumovax) _____
Flu Vaccine _____COVID_____ Hepatitis B _____

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

General:	**Breast:**	**Genital urinary**
Appetite Loss	Breast swelling	Frequent urination
Chills	Breast lump	Painful urination
Fever	Nipple discharge	Difficult to urinate
Night Sweats	Pain in Breast	Blood in urine
Weight gain		Incontinence
Weight loss	**Cardio Vascular, Heart :**	Bladder infections
Head Neck:	Chest Pain	Kidney stones
Head injury	Heart Murmur	Prostate problems
Dizzy spells	Irregular Heart Beat	**Musculoskeletal:**
Hearing changes	Chest Tightness	Back pain
Ringing in Ears	High Blood pressure	Joint Pain
Vision change	Heart Attack	
Nose Bleeds	Hypertension	**Neurologic:**
Sinus Trouble	**Abdomen and GI:**	Headache/migraines
Sore Throat	Gallstones	Stroke
Hoarseness	Hepatitis	Seizure
Neck Swelling	Abdominal pain	Memory Loss
Thyroid Problems	Diverticulosis	Sleep problems
Snoring	Heart Burn	Daytime sleepiness
Respiratory:	Swallowing problems	**Endocrine:**
Cough	Nausea/vomiting	Diabetes
Shortness of breath	Diarrhea	Thyroid problems
Difficulty breathing	Constipation	**Hematology:**
Sputum production	Hemorrhoids	Anemia
Wheezing	Black/bloody stools	Bleeding
	Ulcer	

Note: any system symptoms not listed above are negative unless checked

End of Life Planning:
Have you completed an "Advanced Directive"? _____
Do you want more information about End of Life Planning? _____yes _____No