This questionnaire is important to your health. We will rely on your responses when treating you. Please take the time to provide this information completely and accurately.

SOUTHERN FAMILY MEDICINE, LLC
16312 Mount Airy Road, Shrewsbury, PA 17361
Phone: (717) 227-3800 ♦ Fax: (717) 227-3802
www.SouthernFamilyMed.com

PATIENT HISTORY QUESTIONNAIRE

Today's Date: ______________________

Si usted no habla inglés fluido, marque por favor esta caja: ☐ ***y termine tanto de esta forma como usted puede.***

PART 1: PATIENT INTRODUCTION

Patient Name: ____
First — Middle — Last — Suffix (Jr, III, etc.)

Address: ____
Number and Street — Apartment / Unit

____
City — State — Zip

Home Phone: ( ) - ____________ Area Code

Work Phone: ( ) - ____________ Area Code

Gender: (check one) ☐ Male ☐ Female

Date of Birth: ____ / ____ / ____ Month Day Year

Occupation: ______________________

Soc. Sec. No.: ____ - ____ - ____

Employer: ______________________

Marital Status: (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Spouse/Partner Name: ______________________

Spouse/Partner Occupation: ______________________

If English is **not** your primary language, what is your primary language? ______________________ } *Leave this line blank if English* ***is*** *your primary language.*

Who accompanied you to our office? ______________________ If no one, leave blank

Relationship to you: ______________________

How did you learn about us? (check all that apply)

☐ Received advertisement by mail
☐ Saw sign in front of building
☐ Referral
☐ Found on the Internet
☐ Other – please describe: ______________________

If referred, by whom? ______________________ Relationship to you: ______________________

If you want to communicate with Southern Family Medicine by e-mail, please ask for a copy of our Patient E-Mail Guidelines.

PART 2: REASON(S) FOR VISIT

Using the space provided, briefly state the 3 main reasons for your visit.

1. ______________________
2. ______________________
3. ______________________

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PART 3: PAST MEDICAL HISTORY

Instructions: Please check the box next to each medical problem you have now or have had in the past and indicate the year it started.

If you have or have had this:	*Check here:*	*What year did it start?*	*If you have or have had this:*	*Check here:*	*What year did it start?*	*If you have or have had this:*	*Check here:*	*What year did it start?*
Mumps	☐	______	Thyroid problem	☐	______	Scarlet fever	☐	______
Measles	☐	______	Whooping cough	☐	______	Diphtheria	☐	______
Chicken Pox	☐	______	COPD / emphysema	☐	______	Pneumonia	☐	______
Polio	☐	______	Heart disease	☐	______	Rheumatism	☐	______
Asthma	☐	______	Heart failure	☐	______	Arthritis	☐	______
Anemia	☐	______	High cholesterol	☐	______	Joint disease	☐	______
Meningitis	☐	______	Kidney disease	☐	______	Blood clots	☐	______
Influenza	☐	______	Bursitis/sciatica	☐	______	Bladder prob.	☐	______
Tuberculosis	☐	______	Gallbladder disease	☐	______	Liver disease	☐	______
Cancer	☐	______	Migraine headaches	☐	______	Seizures	☐	______
Diabetes	☐	______	Bowel disease	☐	______	Hemorrhoids	☐	______
Jaundice	☐	______	High blood pressure	☐	______	Chlamydia	☐	______
Eczema	☐	______	Neuritis/neuralgia	☐	______	Gonorrhea	☐	______
Allergies	☐	______	Frequent infections	☐	______	Depression	☐	______
Anxiety	☐	______	Rectal disease	☐	______	Panic attacks	☐	______
HIV/AIDS	☐	______	Bone disease	☐	______	Other *	☐	______

* If you checked “Other,” please list the other medical conditions you have or had:

HOSPITALIZATIONS / SURGERIES / SEVERE INJURIES

List all times and reasons that you have been hospitalized, operated on, or severely injured.

Date	Reason for hospital admission, type of surgery and/or nature of severe injury	Doctor who treated you

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PART 4: PAST & PRESENT SYMPTOMS

Instructions: Please check the box next to each symptom you have now or have had in the past year and indicate the year it started.

If you have or have had this:	*Check here:*	*Year started:*	*If you have or have had this:*	*Check here:*	*Year started:*	*If you have or have had this:*	*Check here:*	*Year started:*
Blurred vision	☐	______	Joint swelling	☐	______	Difficulty urinating	☐	______
Dizziness	☐	______	Fainting spells	☐	______	Painful urination	☐	______
Headaches	☐	______	Discharge from ears	☐	______	Urinate less than usual	☐	______
Earaches	☐	______	Ringing in ears	☐	______	Urinate more than usual	☐	______
Change in taste	☐	______	Decrease in hearing	☐	______	Blood in urine	☐	______
Enlarged glands	☐	______	Recurrent nose bleeds	☐	______	Lose urine w/ coughing, etc.	☐	______
Chest pain	☐	______	Persistent hoarseness	☐	______	Pain with bowel movement	☐	______
Muscle spasm	☐	______	Difficulty swallowing	☐	______	Blood in bowel movement	☐	______
Stomach pain	☐	______	Chronic frequent cough	☐	______	Change in bowel movement	☐	______
Heartburn	☐	______	Leg cramps at night	☐	______	Vomited / coughed up blood	☐	______
Dentures	☐	______	Nausea or vomiting	☐	______	Fatigue	☐	______
Pain in arm(s)	☐	______	Wake up short of breath	☐	______	Recurrent back pain	☐	______
Night sweats	☐	______	Shortness of breath	☐	______	Palpitations/fluttering of heart	☐	______
Easy bruising	☐	______	Change in appetite	☐	______	Nail brittleness	☐	______
Hot flashes	☐	______	Abdominal cramps	☐	______	Weakness of hands or feet	☐	______
Skin rash	☐	______	Change in hair texture	☐	______	Trembling of any extremity	☐	______
Dryness of skin	☐	______	Inability to tolerate heat	☐	______	Hand, feet or ankle swelling	☐	______
Excessive sweating	☐	______	Inability to tolerate cold	☐	______	Tingling of hands or feet	☐	______
Spots before eyes	☐	______	Eyeglasses needed	☐	______	Leg cramps while walking	☐	______
Pain behind eyes	☐	______	Recurrent sore throats	☐	______	Enlarged veins in legs	☐	______
Change in vision	☐	______	Soreness/bleeding gums	☐	______	Redness or heat in joints	☐	______
Sinus trouble	☐	______	Recurrent head colds	☐	______	Other *	☐	______
Hay fever	☐	______	Change in smell	☐	______		☐	______

* If you checked “Other,” please list the other symptoms you have or had in the past year:

PART 5: EXERCISE

Do you exercise? ☐ Yes ☐ No If yes, how often? ______________________

If yes, what kind of exercise? ______________________

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PART 6: MEDICATIONS / SUPPLEMENTS / IMMUNIZATIONS

Instructions: Please list all medications, vitamins or supplements you are taking now, including non-prescription items.

Name of medication, vitamin or supplement	Dosage / Strength	Times per day	Reason

IMMUNIZATIONS / VACCINATIONS

If you received this vaccination:	Check here:	Year received:	Have you received a booster?	Year of last booster:	Describe adverse reactions, if any:
DPT	☐		☐ Yes ☐ No		
Diphtheria	☐		☐ Yes ☐ No		
Pertussis	☐		☐ Yes ☐ No		
Tetanus	☐		☐ Yes ☐ No		
Measles	☐		☐ Yes ☐ No		
Mumps	☐		☐ Yes ☐ No		
Rubella	☐		☐ Yes ☐ No		
Polio	☐		☐ Yes ☐ No		
Hepatitis	☐		☐ Yes ☐ No		
Flu	☐		☐ Yes ☐ No		
Pneumovax	☐		☐ Yes ☐ No		
Chickenpox	☐		☐ Yes ☐ No		
Other – specify: ____________			☐ Yes ☐ No		

Have you had a Tuberculin (TB) skin test? ☐ Yes ☐ No Year: ________ Was it: ☐ Positive or ☐ Negative?

If positive, provide the year you were treated: ____________________

Have you been out of the country in the last 2 years? ☐ Yes ☐ No When? ____________________

Where did you go? ____

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PART 7: FAMILY HISTORY

Instructions: Please indicate which, if any, family members have had the following health issues.

Health issue			If Yes, relationship of family member:	Health issue			If Yes, relationship of family member:
Heart failure	☐ Yes	☐ No		Cancer	☐ Yes	☐ No	
Heart attack	☐ Yes	☐ No		Seizure disorder	☐ Yes	☐ No	
High blood pressure	☐ Yes	☐ No		Kidney disease	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No		Liver disease	☐ Yes	☐ No	
Bleeding disorder	☐ Yes	☐ No		Mental disorder	☐ Yes	☐ No	
High cholesterol	☐ Yes	☐ No		Alcoholism / addiction	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No		Suicide	☐ Yes	☐ No	
Blood clots	☐ Yes	☐ No		Other: ______________________			

Instructions: Please provide the following information about your family members. For each family member who is alive, Indicate any significant health issues he/she has now. For each family member who is deceased, any significant health issues he/she had while alive.

Family Member	Deceased?	Age, if alive:	If deceased: Age at death:	Year of death:	Cause:	Health Issues
Husband / Wife	☐ Yes ☐ No					
Father	☐ Yes ☐ No					
Mother	☐ Yes ☐ No					
Siblings:						
#1: ☐ Brother ☐ Sister	☐ Yes ☐ No					
#2: ☐ Brother ☐ Sister	☐ Yes ☐ No					
#3: ☐ Brother ☐ Sister	☐ Yes ☐ No					
#4: ☐ Brother ☐ Sister	☐ Yes ☐ No					
Children:						
Name: ____________	☐ Yes ☐ No					
Name: ____________	☐ Yes ☐ No					
Name: ____________	☐ Yes ☐ No					
Name: ____________	☐ Yes ☐ No					

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PART 8: ALLERGIES, SENSITIVITIES & INTOLERANCES

Instructions: Please list anything you are allergic to, such as foods, medications, dust or chemicals, and indicate how each affects you (e.g., nausea, hives, difficulty breathing, etc.)

Allergic, Sensitive or Intolerant to:	Effect:

Do you live with a pet? ☐ Yes ☐ No If yes, what kind? ____________ How many?________

Do you have any adverse reactions to your pet(s)? ☐ Yes ☐ No

PART 9: VISION AND DENTAL HISTORY

VISION / EYESIGHT:

Date of last eye examination: ____________

Do you wear eyeglasses or contact lenses? ☐ Yes ☐ No

DENTAL:

Date of last dental examination: ____________

PART 10: SMOKING / ALCOHOL / DRUG HISTORY

PLEASE NOTE: For us to provide you with proper medical care, it is important that you answer the following questions accurately.

SMOKING

Do you smoke now? .... ☐ Yes ☐ No

If yes: Number of years you have smoked: ________ Number of packs you smoke per day:________

If you do not smoke now, have you ever smoked? .... ☐ Yes ☐ No

If yes: Number of years you smoked: ________ Year when you quit:________

Do you chew tobacco? .... ☐ Yes ☐ No

Does anyone else in your house smoke? .... ☐ Yes ☐ No

ALCOHOL

How many drinks do you normally have?

Beer: ________ per (check one): ☐ day ☐ week ☐ month

Wine: ________ per (check one) : ☐ day ☐ week ☐ month

Hard liquor: ________ per (check one) : ☐ day ☐ week ☐ month

Have you ever had a problem with alcohol? ☐ Yes ☐ No

DRUG USE

Have you ever used illicit drugs? .... ☐ Yes ☐ No

Have you ever smoked marijuana? .... ☐ Yes ☐ No

Have you ever been treated for drug use? .... ☐ Yes ☐ No

Aside from marijuana, please list other illicit drugs you have used: ____________

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PART 11: QUESTIONS FOR FEMALE PATIENTS ONLY

a. *Age* periods began (onset of menarche) .... ________

b. *Year* periods began (onset of menarche). .... ________

b. Date of last menstrual period (LMP) .... ____/____/____

c. How many days from the start of one period to the start of the next? .... ________

d. How many days does your period last? .... ________

e. Is your cycle regular? .... ☐ Yes ☐ No

f. Do you pass any clots? .... ☐ Yes ☐ No

g. Is the flow .... ☐ Heavy, ☐ Medium, or ☐ Light?

h. On heavy days, how many of each do you use? .... Tampons: ________ Pads: ________

i. Do you have cramps before or during your period? .... ☐ Yes ☐ No

j. Have you experienced any change in breast size? .... ☐ Yes ☐ No

k. Do you examine your breasts? .... ☐ Yes ☐ No

l. Do you experience tender breasts? .... ☐ Yes ☐ No If yes, when? ________

m. Do you have nipple discharge? .... ☐ Yes ☐ No If so, what color? ________

n. Date of last mammogram: .... ________ Findings: ________

o. Age of menopause .... ________ or, ☐ n/a

p. Year of menopause .... ________ or, ☐ n/a

q. Do you have hot flashes? .... ☐ Yes ☐ No

r. Have you ever taken estrogen or hormone replacement therapy (HRT)? .... ☐ Yes ☐ No

If so: At what age did you receive HRT? ________ In what year did you receive HRT? ________

s. Do you take calcium supplements? .... ☐ Yes ☐ No

t. Have you had a DEXA scan? .... ☐ Yes ☐ No If so, when? ________

u. Date of last pelvic/gynecological exam: ...... ________ Result: ________

v. Date of last pap test: .... ________ Result: ________

w. Do you experience itching or burning in your vaginal area? .... ☐ Yes ☐ No

x. Do you experience discharge from your vagina? .... ☐ Yes ☐ No

If so: Amount: ________ Color: ________

y. Have you used: *Birth control pills?* ☐ Yes ☐ No *IUD?* ☐ Yes ☐ No *A birth control patch?* ☐ Yes ☐ No

z. Describe any problems you have experienced with any birth control method: ________

____

Have you been pregnant? ☐ Yes ☐ No *Number of:* Miscarriages/abortions: ______ Stillbirths: ______

Please provide details about pregnancies:	Year: ________	☐ Vaginal, or ☐ C-Section	☐ Term, or ☐ Pre-Term	Complications:
	Year: ________	☐ Vaginal, or ☐ C-Section	☐ Term, or ☐ Pre-Term	Complications:
	Year: ________	☐ Vaginal, or ☐ C-Section	☐ Term, or ☐ Pre-Term	Complications:
	Year: ________	☐ Vaginal, or ☐ C-Section	☐ Term, or ☐ Pre-Term	Complications:

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PART 12: OTHER INFORMATION / CONTINUATION OF RESPONSES

Instructions: Please use the space below to:
1. Provide any additional information that you believe may be important for us to know about your health, and
2. Continue any responses from previous questions (if you require additional space).

PART 13: SIGNATURES

Please sign below. By doing so, you are certifying that the responses in this questionnaire are complete and accurate to the best of your belief.

Patient Signature: ____________________

If patient is unable to sign, check here and provide reason: ☐ Reason: ____________________

If you are not the patient, but you completed this questionnaire for the patient, please sign below. By doing so, you are certifying that the responses in this questionnaire are complete and accurate to the best of your belief.

Signature of person completing this questionnaire: ____________________
(only if different from patient)

Print your name: ____________________

Relationship to patient: ____________________

THIS IS THE END OF THE QUESTIONNAIRE. THANK YOU.

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