Sound Health
PHYSICIANS

QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name		O M O F	**DOB:**	

Marital status:	O Single O Partnered O Married O Separated O Divorced O Widowed

Previous or referring doctor:		**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Childhood illness:	O Measles O Mumps O Rubella O Chickenpox O Rheumatic Fever O Polio			
Immunizations and dates:	O Tetanus		O Pneumonia	
	O Influenza		O Chickenpox	
	O Meningococcal		O Shingles	
	O HPV		O MMR	
	O Polio			
	O Hepatitis **A**		O Hepatitis **B**	
	O Yellow Fever		O Typhoid	

Please list any current or past medical issues (include dates if you know them)

Surgeries & Procedures (please include surgeon if you remember)

In addition to any surgeries, need to know all procedures done including colonoscopy, endoscopy, oral surgery, cosmetic surgery, and colposcopy.

Year	Reason	Where?
	Colonoscopy	

Hospitalizations & Emergency Department / Urgent Care

Year	Reason	Where?

Have you ever had a blood transfusion?	☐	Yes	☐	No

List your prescribed drugs and over-the-counter drugs, such as vitamins, supplements, eye drops and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications, foods, environmental factors		
Name of Medication, Food, Environmental Factor	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

PLEASE RANK YOUR HEALTH HABITS				
Exercise	O A: *I exercise for an hour or more most days of the week*			
	O B: *I exercise 3-5 times a week for 30-60 minutes*			
	O C: *I exercise 1-3 times a week for 30-60 minutes*			
	O D: *I exercise infrequently or not at all*			
Stress	O A: *I have a very high amount of stress all of the time*			
	O B: *I have a high amount of stress, but not all of the time*			
	O C: *I have a normal degree of stress when compared to others*			
	O D: *I currently have little or no stress in my life*			
Dental Health	O A: *I see my dentist at least twice a year and have normal check-ups*			
	O B: *I see my dentist once per year and have normal check-ups*			
	O C: *I see my dentist for gum disease or have gum disease*			
	O D: *I don't currently see a dentist*			
Diet	O A: *I eat healthy meals on most days including 4-5 servings of fruits and vegetables*			
	O B: *I eat healthy meals 3-5 times per week including 4-5 servings of fruits and vegetables*			
	O C: *I eat 1-2 healthy meals per week*			
	O D: *I am too busy and often eat prepared, fast, and restaurant food*			
	O E: *I eat when I'm bored or distressed or feel that I overeat*			
Caffeine	O None	O Coffee	O Tea	O Cola or Energy Drinks
	# Of cups/cans per day?			
Alcohol	Do you drink alcohol?		O Yes	O No
	If yes, what kind?			
	How many drinks per week?			

	Are you or others concerned about the amount you drink?					O Yes	O No
	Have you considered stopping?					O Yes	O No
	Have you ever-experienced blackouts?					O Yes	O No
	Are you prone to “binge” drinking?					O Yes	O No
	Do you drive after drinking?					O Yes	O No
Tobacco	Do you use tobacco?					O Yes	O No
	O Cigarettes packs per day?	O Chew · #/day	O Pipe · #/day	O Cigars · #/day			
	# of years	Or year quit					
Drugs	Do you currently use recreational or street drugs? (This includes anabolic steroids.)					O Yes	O No
	Have you ever given yourself street drugs with a needle?					O Yes	O No
Sleep	Have you been told (or noticed on your own) that you snore on most nights?					O Yes	O No
	Have you been told (or noticed on your own) that you stop breathing or struggle to breathe in your sleep?					O Yes	O No
	Are you tired, fatigued or sleepy on most days?					O Yes	O No
	Do you have acid indigestion or high blood pressure (or use medication to control either of these conditions?)					O Yes	O No
	Are you overweight?					O Yes	O No
Sex	Are you sexually active?					O Yes	O No
	If yes, are you trying for a pregnancy?					O Yes	O No
	If not trying for a pregnancy list contraceptive or barrier method used:						
	Any discomfort with intercourse?					O Yes	O No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?					O Yes	O No
Personal Safety	Do you live alone?					O Yes	O No
	Do you have frequent falls?					O Yes	O No
	Do you have vision or hearing loss?					O Yes	O No
	Do you have an Advance Directive, Living Will or POLST form? (we would like to have a copy of these forms)					O Yes	O No
	Would you like information on the preparation of these?					O Yes	O No
	Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?					O Yes	O No

FAMILY HEALTH HISTORY

	AGE	HEALTH ISSUES		AGE	HEALTH ISSUES
Father			**Children**	O M O F	
Mother				O M O F	
Sibling	O M O F			O M O F	
	O M O F			O M O F	
	O M O F		**Grandmother** *Maternal*		
	O M O F		**Grandfather** *Maternal*		
	O M O F		**Grandmother** *Paternal*		
	O M O F		**Grandfather** *Paternal*		

MENTAL HEALTH

Do you feel depressed?	O Yes	O No
Do you panic when stressed?	O Yes	O No
Do you have problems with eating or your appetite?	O Yes	O No
Do you cry frequently?	O Yes	O No
Have you ever attempted suicide?	O Yes	O No
Have you ever seriously thought about hurting yourself?	O Yes	O No
Have you ever been to a counselor?	O Yes	O No

GOAL SETTING

Please tell us your **current health & wellness goals**. We would like to work with you to achieve these goals and can help you.

Goal	**Priority (A-F)** **A=Very Important** **F=Unimportant**

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	O Yes	O No
Number of pregnancies _____ Number of live births _____		
Are you taking Estrogen Replacement or Oral Birth Control?	O Yes	O No
Are you pregnant or breastfeeding?	O Yes	O No
Have you had a D&C, hysterectomy, or Cesarean?	O Yes	O No
Any urinary tract, bladder, or kidney infections within the last year?	O Yes	O No
Any blood in your urine?	O Yes	O No
Any problems with control of urination?	O Yes	O No
Any hot flashes or sweating at night?	O Yes	O No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	O Yes	O No
Experienced any recent breast tenderness, lumps, or nipple discharge?	O Yes	O No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	O Yes	O No
If yes, # of times _____		
Do you feel pain or burning with urination?	O Yes	O No
Any blood in your urine?	O Yes	O No
Do you feel burning discharge from your penis?	O Yes	O No
Has the force of your urination decreased?	O Yes	O No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	O Yes	O No
Do you have any problems emptying your bladder completely?	O Yes	O No
Any difficulty with erection or ejaculation?	O Yes	O No
Any testicle pain or swelling?	O Yes	O No
Date of last prostate and rectal exam? (by whom?)	O Yes	O No

OTHER ISSUES

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain:

O Skin	O Chest/Heart	O Recent changes in:
O Head/Neck	O Back	O Weight
O Ears	O Intestinal	O Energy level
O Nose	O Bladder	O Ability to sleep
O Throat	O Bowel	O Other pain/discomfort:
O Lungs	O Circulation	