FCA
FIAT CHRYSLER AUTOMOBILES

FAMILY HEALTH & WELLNESS CENTER
POWERED BY St. Vincent

1765 East Lincoln Road, Kokomo, IN 46902
Phone: 765-236-8380 Fax: 765-236-8381

HEALTH HISTORY QUESTIONNAIRE

Today's Date _____/_____/_____

	Male Female	**/ /**	
Patient's Name (Last, First, Middle Initial)	Gender (Circle One)	Birth date	Age
	( ) ( )		
Emergency Contact	Home Phone #	Cell Phone #	

REASON FOR YOUR VISIT

CURRENT MEDICAL PROBLEMS

What current medical problems do you want the doctor and nurse practitioner to address:

PHARMACY AND TESTING INFORMATION

_____
Preferred Pharmacy (store address and phone number)

_____
Preferred Laboratory (address and fax number)

_____
Preferred Imaging (address and phone number)

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CONSULTANTS

Include all Doctors, Dentist and Ophthalmologist.

First Name	Last Name	Specialty	City and State	Phone	Fax

If there are any previous consultants that you no longer see, but you would like us to obtain their records, please list them here.

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ALLERGIES

Have you had hives, skin rash, breathing problems or other allergic reactions to medicine or any other substance? Yes ☐ No ☐
If Yes, please specify below:

Name of Medication/Substance	Describe Allergic Reaction

	Yes	No	
Have you had a reaction to seafood, iodine or contrast dye?	☐	☐	
Have you had reactions to latex/rubber/adhesive tape?	☐	☐	
Have you had any reaction to food, mold, dust or bee stings?	☐	☐	

MEDICATIONS

Identify prescription/non-prescription medications you use or have recently used (include vitamins, nutritional supplements, oral contraceptives, pain relievers and cold medicines).

Name of Medication	Dose (Milligrams)	Frequency (Times/day)	When Stopped	Refills Needed
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IMMUNIZATIONS

Have you been immunized against the following? If yes, please indicate the year in which it was given.

	Yes	No	Unknown	Year	MD/Provider use only
Measles	☐	☐	☐		
Mumps	☐	☐	☐		
Rubella	☐	☐	☐		
Polio	☐	☐	☐		
Pneumonia (at age 65 unless at high risk)	☐	☐	☐		
Hepatitis A	☐	☐	☐		
Hepatitis B	☐	☐	☐		
Influenza (every Fall)	☐	☐	☐		
Tetanus/Diphtheria /Pertussis (every ten years)	☐	☐	☐		
Shingles (at age 50)	☐	☐	☐		
Travel	☐	☐	☐		
Other	☐	☐	☐		

FAMILY HISTORY

	Living?	Current Age	Deceased?	Age at Death	Cause(s) of Death?
Father	☐ Yes		☐ Yes		
Mother	☐ Yes		☐ Yes		
Brother	☐ Yes		☐ Yes		
Sister	☐ Yes		☐ Yes		
Brother	☐ Yes		☐ Yes		
Child (M or F)	☐ Yes		☐ Yes		
Child (M or F)	☐ Yes		☐ Yes		
Child (M or F)	☐ Yes		☐ Yes		
Child (M or F)	☐ Yes		☐ Yes		
Child (M or F)	☐ Yes		☐ Yes		

Have any of the following illnesses occurred in your blood relatives (grandparents, parents, brothers, sisters, or children)?

Yes	No		Which Relative(s)
☐	☐	Cancer, *if Yes type of Cancer* _____	
☐	☐	Stroke	
☐	☐	High Blood Pressure	
☐	☐	Heart disease, *if Yes age at onset* _____	
☐	☐	Liver disease	
☐	☐	Stomach/Bowel Disease	
☐	☐	Kidney Disease	
☐	☐	Diabetes	
☐	☐	High Cholesterol	
☐	☐	Lung Disease	
☐	☐	Joint Disease/Arthritis	
☐	☐	Alcohol/drug abuse	
☐	☐	Genetic Disease	
☐	☐	Anxiety/Depression/Psychiatric	
☐	☐	Sudden Death	
☐	☐	Other	

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SOCIAL HISTORY

Smoking status:
☐ Never ☐ Former smoker ☐ Current every day smoker ☐ Current some day smoker

Smoking how much:
☐ None ☐ 1PPW ☐ 2PPW ☐ ¼ PPD ☐ ½ PPD ☐ 1PPD ☐ 1 ½ PPD ☐ 2 PPD ☐ 3+ PPD

Tobacco years of use: _____

When did you quit smoking? _____

Other form of tobacco:
☐ chewing tobacco/snuff ☐ patch ☐ gum ☐ lozenge ☐ e-cigarette/ vape ☐ cigar ☐ hooka

Any illicit drug use? ☐ Yes ☐ No **Type:**_____

Current Occupation: _____

Education level:
☐ Less than 8th grade ☐ 8th grade ☐ 9th grade ☐ 10th grade ☐ 11th grade ☐ 12th grade
☐ 2 year college ☐ 4 year college ☐ Post Graduate

Marital status:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Unknown

Exercise level:
☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Diet:
☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten free ☐ Specific: _____
☐ Carbohydrate ☐ Cardiac ☐ Diabetic

General stress level:
☐ Low ☐ Medium ☐ High

Alcohol Intake:
☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Caffeine intake:
☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Guns present in the home?	☐ Yes	☐ No
Seat belts used routinely?	☐ Yes	☐ No
Sunscreen used routinely?	☐ Yes	☐ No
Smoke alarm in home?	☐ Yes	☐ No
Do you have an advance Directive?	☐ Yes	☐ No
Do you have a medical power of attorney?	☐ Yes	☐ No
Do you preform monthly self-breast exams?	☐ Yes	☐ No
Have you ever been diagnosed legally blind?	☐ Yes	☐ No
Have you ever been diagnosed legally deaf?	☐ Yes	☐ No

EXERCISE HISTORY

Are you currently involved in a regular exercise program? ☐ Yes ☐ No

If yes, how long? _____

Do you participate in regular daily activities such as yard work, house work, cleaning, walking pets, etc.? ☐ Yes ☐ No

If yes, what type and how often?_____

What type of cardiovascular exercise do you perform (walk, run, swim, bike, elliptical, etc.) ?_____

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How often (days/week)?_____ How long (minutes)?_____

How hard? ☐ Fairly Light ☐ Light ☐ Somewhat Hard ☐ Hard

What type of strength training/weight lifting exercises do you perform (dumbbells, free weights, weight machines, etc.) ?_____

How often (days/week)?_____ How long (minutes)?_____

How hard? ☐ Fairly light ☐ Light ☐ Somewhat hard ☐ Hard

What type of flexibility exercises do you perform (stretching, yoga, Pilates, etc.) ?_____

How often (days/week)?_____ How long (minutes)?_____

How hard? ☐ Fairly light ☐ Light ☐ Somewhat hard ☐ Hard

PAST SURGICAL HISTORY

Have you ever had surgery? ☐ Yes ☐ No If *Yes, please list the surgery and the year in which you had the surgery.*

Surgery _____ Year _____
Surgery _____ Year _____
Surgery _____ Year _____
Surgery _____ Year _____
Surgery _____ Year _____
Surgery _____ Year _____
Surgery _____ Year _____

HOSPITALIZATION

Reason _____ Date _____
Reason _____ Date _____
Reason _____ Date _____
Reason _____ Date _____

ER VISITS

Reason _____ Date _____
Reason _____ Date _____
Reason _____ Date _____
Reason _____ Date _____

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FEMALE PATIENTS ONLY

GYNECOLOGICAL HISTORY

Age at menopause? _____

When was your last menstrual cycle? ____/____/____
Frequency of Cycle _____
Menses Monthly ____Yes or No_____
Duration of Flow Days _____
Flow: Light Moderate Heavy

When was your last screening mammogram? ____/____/____

When was your last pap smear and pelvic exam? ____/____/____

When was your last bone density? ____/____/____

Are you on HRT (Hormone Replacement Therapy)? ____Yes or No____

Have you had HPV (Human Papillomavirus)? ____Yes or No____

OBSTETRIC HISTORY

Total number of pregnancies _____
Full Term _____ Premature _____

Abortions (Induced) _____

Miscarriages (abortions spontaneous) _____

Ectopic pregnancies _____

Multiple Births _____

Living Children _____

PREVENTIVE HEALTH

When was your last Eye examination? ____/____/____

When was your last Dental examination? ____/____/____

When was your last Screening Colonoscopy? ____/____/____

When was your last Screening Dermatology exam? ____/____/____

When was your last Exercise Stress Test? ____/____/____

When was your last Abdominal Aorta Ultrasound? ____/____/____

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MALE PATIENTS ONLY

PROSTRATE HISTORY

When was your last prostate exam? _____/_____/_____

When was your last PSA (lab work to check for possible prostate cancer? _____/_____/_____

PREVENTIVE HEALTH

When was your last Eye examination? _____/_____/_____

When was your last Dental examination? _____/_____/_____

When was your last Screening Colonoscopy? _____/_____/_____

When was your last Screening Dermatology exam? _____/_____/_____

When was your last Exercise Stress Test? _____/_____/_____

When was your last Abdominal Aorta Ultrasound? _____/_____/_____

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INSTRUCTIONS: Please check boxes in front of conditions associated with your personal medical history

PAST MEDICAL HISTORY

Conditions		Conditions
Head, Ears, Eyes, Nose, Throat		☐ Anxiety
☐ Allergies		☐ Depression
☐ Glaucoma		☐ Illicit Drug Use
☐ Cataracts		☐ Psychiatric Illness
☐ Glasses/Contacts		☐ Other Psychiatric Issue
☐ Hay Fever		**Respiratory**
☐ Hearing Loss		☐ Asthma
☐ Hearing Problems		☐ COPD
☐ Vision or Eye Problems		☐ Emphysema
Cardiovascular		☐ Lung Disease
☐ Aneurysm		☐ Pulmonary Embolism
☐ Aortic Aneurysm		☐ Tobacco Abuse
☐ Arrhythmia		☐ Tuberculosis
☐ Atrial Fibrillation		☐ Other Respiratory Issue
☐ Cardiomyopathy		**Gastrointestinal**
☐ Carotid Disease		☐ Acid Reflux/GERD
☐ Stroke		☐ Constipation
☐ Congestive Heart Failure		☐ Diarrhea
☐ Coronary Artery Disease		☐ Diverticulitis
☐ Deep Vein Thrombosis		☐ Diverticulosis
☐ Heart Arrhythmia		☐ Gastrointestinal Disease
☐ Heart Attack (MI)		☐ Hepatitis
☐ Heart Disease		☐ Hernia
☐ Heart Murmur		☐ Hiatal Hernia
☐ Heart Problems		☐ Liver Disease
☐ High Blood Pressure		☐ Ulcers
☐ High Cholesterol		☐ Other Gastrointestinal Issue
☐ Hyperlipidemia		**Endocrine**
☐ Leg or Foot Ulcers		☐ Diabetes Mellitus
☐ Obesity		☐ Hyperthyroidism
☐ Pacemaker		☐ Hypothyroidism
☐ Peripheral Arterial Disease		☐ Thyroid Disease
☐ Other Cardiovascular Disease		☐ Other Endocrine Issue
Genitourinary		**Musculoskeletal**
☐ Bladder Problems		☐ Arthritis
☐ Dialysis		☐ Back Pain
☐ Endometriosis – **FEMALE ONLY**		☐ Back Problems
☐ Genitourinary Disease		☐ Chronic Pain
☐ Infertility		☐ Musculoskeletal Disease
☐ Kidney Disease		☐ Osteoporosis
☐ Kidney Stones		☐ Other Musculoskeletal Issue
☐ Enlarged Prostate – **MALE ONLY**		**Neurological**
☐ Urinary Tract Infections		☐ Epilepsy
☐ Other Genitourinary Issue		☐ Head Trauma
Psychiatric		☐ Headaches
☐ Addiction		☐ Migraines
☐ Alcohol Abuse		☐ Multiple Sclerosis
☐ Anxiety		☐ Neck Injury

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☐ Neurologic Disease		**Pediatric**
☐ Seizures		☐ ADD or ADHD
☐ Stroke		☐ Bedwetting
☐ Other Neurologic Issue		☐ Birth Defects or Inherited Disease
Hematology/ Cancer		☐ Chicken Pox
☐ Anemia		☐ Congenital Anomalies
☐ Bleeding Disorder		☐ Congenital Heart Disease
☐ Blood Clots		☐ Developmental Delay
☐ Blood Diseases		☐ Developmental or Behavioral Disorder
☐ Breast Cancer		☐ Hospital Admission Other Than Birth
☐ Cancer		☐ Speech Delay
☐ Colonoscopy		☐ Other Pediatric Issue
☐ Ovarian Cancer		**Other**
Skin		☐ Anesthesia Complications
☐ Eczema		☐ Breast Problems
☐ Hives		☐ Infectious Disease
☐ Skin Conditions		☐ Organ Transplant
☐ Other Skin Disorder Issue		☐ Irritable Bowel Syndrome
Rheumatologic		☐ Serious Illness or Injuries
☐ Fibromyalgia		**Abnormal Laboratory**
☐ Gout		☐ High Cholesterol
☐ Immune System Disorder		☐ Elevated Fasting Blood Sugar
☐ Lupus		☐ Abnormal Liver Function Tests
☐ Osteoarthritis		☐ Low Blood Count
☐ Rheumatoid Arthritis		**Blood Disorders**
Sexually Transmitted Diseases		☐ Anemia
☐ HIV or AIDS		☐ Blood Transfusions
☐ Other STD Issue		
Sleep		
☐ Sleep Apnea		
☐ Sleep Disorder		
☐ Other Sleep Issue		