DURANT FAMILY MEDICINE CLINIC HEALTH QUESTIONNAIRE

Name: Date: Birthday: Chart #

Reason For Visit

Medical History ***Mark "C" for current problems, check and indicate date when you had any of the following symptoms or diseases.***

	ADHD	Alcohol drinks per week
	ALLERGIC RHINITIS	Tobacco cig/day #years
	ANEMIA	year quit
	ANXIETY	Second Hand Smoke Exposure No Yes
	ARTHRITIS	Caffeine (Coffee /Tea/Soda) Cups per day
	ASTHMA	Illicit Drugs No Yes - Please list
	BACK PAIN CHRONIC LOW	**MEDICAL MARIJUANA CARD _____NO _____YES**
	BOWEL CHANGES/CONSTIPATION/DIARRHEA	Do you exercise regularly ____No ____Yes
	CANCER - what kind?	Sexually Active No Yes
	COPD	**FEMALES - PLEASE COMPLETE THE FOLLOWING:**
	DEPRESSION	Pain / Bleeding during or after sex No Yes
	DIABETES	Menstrual Flow:
	DIVERTICULOSIS	Regular Irregular Painful Cramps
	GERD	Days of Flow Length of Cycle
	HEART PROBLEMS:]	Date - 1st day last period
	HEPATITIS	Number of: Pregnancies Live Births
	HIGH BLOOD PRESSURE	Miscarriages Abortions
	HIGH CHOLESTEROL	Birth Control method
	HYPOTHYROIDISM	Birth Control pill name
	OBESITY	Hot Flashes NO YES
	SEIZURE	Date of last PAP test
	DIFFICULTY WITH URINATION	Normal Abnormal
	OTHER:	Date of last Mammogram
		Normal Abnormal

Hospital Admissions Not Including Pregnancies	Year	HOSPITALIZATION	Year	SURGERY

Family History

FATHER [ ] Diabetes [ ]High Blood Pressure [ ]Heart Disease [ ]Cancer [ ]Stroke [ ]Mental Illness [ ]Other_____

Father - Year of Birth_____ [ ] Alive [ ] Deceased

MOTHER [ ] Diabetes [ ]High Blood Pressure [ ]Heart Disease [ ]Cancer [ ]Stroke [ ]Mental Illness [ ]Other_____

Mother - Year of Birth _____ [ ] Alive [ ] Deceased

SIGN HERE ->

RESPONSIBLE PARTY/GUARDIAN SIGNATURE **DOCTOR SIGNATURE**

List All Medications You Are Taking Now

Medications prescribed by Doctors	Strength	How Often Do You Take This Medication
MEDICINE YOU TAKE NOT PRESCRIBED BY A DOCTOR	**STRENGTH**	**HOW OFTEN DO YOU TAKE THIS MEDICATION**

If you have a Medical Marijuana Card please describe how you use the marijuana (smoke, eat gummies, and how much you use each day)

LIST ALL YOUR ALLERGIES		

Patient_____

Alcohol Use Screening Audit C

Did you have a drink containing alcohol in the past year?

____Yes
____ No

If Yes: How <u>often</u> did you have a drink containing alcohol in the past year?

_____ Never
_____ Monthly or less
_____ Two to four times in a month
_____Two to three times per week
_____Four or more times a week

If Yes: How <u>many</u> drinks did you have on a typical day when you were drinking in the past year?

_____ 1 or 2 _____ 3 or 4 _____ 5 or 6 _____7-9 _____10 or more

If Yes: How often did you have six or more drinks on one occasion in the past year?

_____Never _____Less than monthly _____Monthly _____Weekly _____Daily

Depression Screening PHQ2

Please indicate the answer that best describes you during the past two weeks:

Do you have little interest or pleasure in doing things?

_____Not at all
_____ Several Days
_____More than half the days
_____ Nearly every day
_____ Decline to Specify

Feeling down, depressed or hopeless?

_____Not at all
_____ Several Days
_____More than half the days
_____ Nearly every day
_____ Decline to Specify

Tobacco Control

___Non Smoker

___Chews Tobacco

___Former Smoker **YOU MAY STOP HERE IF YOU DO NOT CURRENTLY SMOKE.**

___Current Smoker ___everyday ___some days, but not every day

___5 or less ___6-10 ___11-20 ___21-30 ___31 or more

After you wake up when do you smoke your first cigarette ___5 min ___6-30min ___31-60min ___after 60

Are you interested in quitting? ___Ready to quit ___Thinking about quitting ___Not ready to quit

Sexual History

Have you had sex in the last 12 months? (vaginal, oral or anal)? _____Yes _____No

With _____Men Only _____Women Only _____With Both Men & Women

Do you use protection? _____Yes _____No

Type of Birth Control: _____

Have you ever had an STD or STI? _____Yes _____No

Chlamydia? _____Yes _____No

Gonorrhea? _____Yes _____No

Syphilis? _____Yes _____No

Herpes? _____Yes _____No

Other? _____Yes _____No

DURANT FAMILY MEDICINE CLINIC

1600 W UNIVERSITY BLVD DURANT, OK 74701 PHONE 580.924.5500 FAX 580.924.1991

DEMOGRAPHICS FOR RETURNING PATIENT

DATE_____/_____/_____

PATIENT NAME_____

LAST **FIRST** **MIDDLE** **(MAIDEN NAME IF MARRIED)**

MAILING ADDRESS_____City_____State_____Zip_____

Home Phone (_____) _____-_____Cell Phone (_____) _____-_____Work Phone (_____) _____-_____

DATE OF BIRTH_____/_____/_____ □Single □Married □Divorced □Widowed □Separated

SSN_____-_____-_____ **[ ]** Retired **[ ]** Disabled Occupation_____

Employer_____ Full Time Part Time Temporary

Employer Address_____City_____State_____Zip_____

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Preferred Pharmacy:_____

RELEASE OF INFORMATION: Information regarding treatment of a minor may only be released after signature of the legal guardian(s). I hereby authorize the release of any information necessary to process insurance claims for services rendered by DURANT FAMILY MEDICINE CLINIC. I hereby authorize DURANT FAMILY MEDICINE CLINIC to release any and all medical information to previous and future physicians involved in my care. If you email our office with a medical question or information you are giving implied consent for information to be transmitted electronically. Our office must have written permission to release information regarding your care to any other person, including but not limited to a spouse, parent, sibling, etc. A valid HIPAA authorization to release protected health information is required prior to release

I acknowledge the person originally listed on my initial visit is authorized to obtain or provide information regarding my appointments, emergency contact, health and financial/insurance information.

I have reviewed Durant Family Medicine Clinic's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document which is posted to the right of the check-in window. The information contained on this demographics form is true and correct.

I acknowledge my original signed Principles of Medical Home which details an agreement between myself and the assigned physician(s) of my care at Durant Family Medicine Clinic.

I acknowledge my original signed Payment Policy.

I acknowledge my original signed Medication Contract and/or Patient-Physician Agreement is still valid.

Any of the above policies previously signed are available for my review upon request.

Date

_____ _____-_____-_____

Signature of Patient /Legal Guardian