# DURANT FAMILY MEDICINE CLINIC HEALTH QUESTIONNAIRE

Name: Date: Birthday: Chart #

**Reason For Visit**

HAVE YOU BEEN OUT OF THE UNITED STATES ___**No** ____ **Yes-Date**_____**Where**_____

**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 |
| | COVID-19 | Date of last Mammogram |
| | OTHER: | Normal Abnormal |
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| **Hospital Admissions** Not Including Pregnancies | Year | HOSPITALIZATION | Year | SURGERY |
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**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**

**Name:** **Date:** **Date of Birth:**

| Medications prescribed by Doctors | Strength | How Often Do You Take This Medication |
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| **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) | | |
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**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**