TORRANCE MEMORIAL
PHYSICIAN NETWORK

INITIAL HEALTH QUESTIONNAIRE

Name *(Please Print)*: _____ Today's Date: _____

Primary Care Physician: _____

Birth Date: _____ Height: _____

Age: _____ Weight: _____

Reason for Visit: _____ How long has this been a problem? _____

How severe is this problem? ☐ Mild ☐ Moderate ☐ Severe ☐ Incapacitating
☐ Other: _____

How frequent is the problem? ☐ Constant ☐ Daily ☐ Weekly ☐ Random
☐ Other: _____

Problem is aggravated by: _____ Relieved by: _____

List of Medications

Medication Name:	Dose:	Taken How/How Often?	Who Prescribed This?

Allergies? ☐ Yes ☐ No Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

Past Medical and Surgical History: (Please list most recent first)

Surgery	Year	Hospitalization	Year

Your Specialists: (Please list those you currently see or have seen)

Name	Specialty	Name	Specialty

☐ ***Please check if you have written additional information on the back of the page.***

TORRANCE MEMORIAL
PHYSICIAN NETWORK

INITIAL HEALTH QUESTIONNAIRE

Name: _____ Today's Date: _____ Date of Birth: _____

Please mark the appropriate box if you have had any of the following:

☐ Acid Reflux	☐ Breast Disease	☐ Fibromyalgia	☐ Kidney Disease	☐ Severe Accident
☐ Allergies	☐ Cancer	☐ Gallbladder Disease	☐ Kidney Stones	☐ Sexually Transmitted Inf.
☐ Anemia	☐ Cataracts/Glaucoma	☐ Gout	☐ Liver Disease	☐ Stroke
☐ Anxiety	☐ Contacts/Glasses	☐ Hearing Aids	☐ Migraines	☐ Thyroid Disorder
☐ Arthritis	☐ COPD/Emphysema	☐ Heart Attack	☐ Osteoporosis	☐ Ulcerative Colitis
☐ Asthma	☐ Crohn's Disease	☐ Heart Disease	☐ Prostate Problems	☐ Ulcers
☐ Atrial Fibrillation	☐ Depression	☐ High Blood Pressure	☐ Rheumatic Fever	
☐ Bipolar Disorder	☐ Diabetes	☐ High Cholesterol	☐ Schizophrenia	☐ Other: _____
☐ Blood Clots	☐ Eczema	☐ Irritable Bowl Synd.	☐ Seizure Disorder	_____

Immediate Family History: (Please note the following diseases: Cancer, Diabetes, High Blood Pressure, Heart Trouble, Stroke, Seizures, Thyroid Disorder, Mental Disorders, Asthma, Osteoporosis, Tuberculosis.)

Family:	Age (if living)	Deceased: (note age and cause)	Healthy or noted Illness(es):	Additional Siblings with age and condition:
Father:				
Mother:				
Brother:				
Sister:				
Son:				
Daughter:				

Has any blood relative other than immediate family ever had the following conditions: (Please specify relationship)

☐ Alcoholism		☐ Diabetes		☐ Obesity	
☐ Allergies		☐ Drug Addiction		☐ Osteoarthritis	
☐ Alzheimer's Disease		☐ Eczema/Hives		☐ Osteoporosis	
☐ Asthma		☐ Heart Disease (CAD)		☐ Seizure Disorder	
☐ Bleeding Disorder		☐ High Blood Pressure		☐ Stroke (CVA)	
☐ Blood Clots		☐ High Cholesterol		☐ Thyroid Disease	
☐ Cancer		☐ Mental Illness			
☐ Depression		☐Migraines		☐ Other:	

☐ ***Please check if you have written additional information on the back of the page.***

TORRANCE MEMORIAL PHYSICIAN NETWORK

INITIAL HEALTH QUESTIONNAIRE

Name: _____ Today's Date: _____ Date of Birth: _____

Social History

Preferred Language: _____ Need Interpreter? ☐ Yes ☐ No

Currently Employed: ☐Yes ☐ No ☐ Retired

Occupation: _____ Hours worked per week: _____

Is your work satisfying and free from undue pressure or stresses? ☐Yes ☐ No

Do you miss much time from work? ☐Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
# of Previous Marriages: _____

How is your relationship with your spouse? _____

Is your sex life satisfying? ☐Yes ☐ No

How is your relationship with your children? _____

Number of Children: _____ Girls _____ Boys

Do you give or receive ongoing care at home? ☐Yes ☐ No To or from whom? _____
Do you have an advanced directive? ☐Yes ☐ No
Does this office have a copy on file? ☐Yes ☐ No

Smoking: ☐ Never ☐ Yes, # of Packs/Day: _____
☐ Former # of Years Smoked: _____

Alcohol: ☐ Never ☐ Yes, # of Drinks/Week: _____
☐ Former Type: _____

Illicit Drugs: ☐ Never ☐ Yes
☐ Former Type: _____

Caffeine Intake: ☐ Yes ☐ No
☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drink ☐ Chocolate Daily Intake: _____

Lifestyle: Are you on a specific diet? ☐Yes ☐ No If yes, which type of diet? _____
Do you exercise regularly? ☐Yes ☐ No If yes, what type of exercise: _____
Number of days per week: _____
Hours per day: _____

Preventive Care: (please give date of last exam)

Exams:	**Date:**	**Screenings:**	**Date:**	**Vaccines:**	**Date:**	**Other**	**Date:**
Physical Exam		Diabetic Screen		Tdap		**Female Only:**	
Dental Exam		Lipid Panel		Gardasil		Pap Smear	
Eye Exam		Colonoscopy		Hep A		Mammography	
EKG		Bone Density		Hep B			
		TB Test		Influenza		**Male Only:**	
Diabetics Only:		STD Testing		Pneumonia		PSA	
Hemoglobin A1C				Zostavax (shingles)			
Urine Micro Alb							
Foot Exam							

Do you take aspirin 81mg daily? ☐Yes ☐ No

☐ ***Please check if you have written additional information on the back of the page.***

PROVIDER INITIALS _____