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: _____

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

Allergy: _____ Reaction: _____

Taking Medications? ☐Yes ☐ No

(List any medications that you are taking including over-the-counter medications, vitamins, laxatives and herbal supplements.)

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

Are you having any problems filling your prescriptions due to the high cost of the medications? ☐Yes ☐ No

Name and Address of Preferred Pharmacy_____

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

Specialty	Name	Specialty	Name

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

Name: _____ Date of birth: _____

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

Surgery	Year	Hospitalization	Year

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.***

Name: _____ Date of birth: _____

Social History

Social History

Tobacco Use: ☐ Never ☐ Former ☐ Current # of Cig/Packs per Day: _____ # of Years Smoked: _____ Type of Tobacco use: _____ Age Started _____ If Former Age Quit _____

Alcohol Use: ☐ Never ☐ Former ☐ Current Type: _____ #Drinks/Week _____

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

Employment: Are you 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

Education: (highest education obtained) _____

Exercise: Do you exercise regularly? ☐Yes ☐ No If yes, what type of exercise: _____ Number of days per week: _____ Hours per day: _____

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

How is your relationship with your spouse? _____ Is your sex life satisfying? ☐Yes ☐ No

Children:

How is your relationship with your children? _____ Number of Children: _____Girls _____ Boys

Nutrition: Are you on a specific diet? ☐Yes ☐ No If yes, which type of diet? _____

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

Preventive Care: (please give date of last exam)

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

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

Name: _____ Date of birth: _____

PHQ

Circle to indicate your answer		
Have you been diagnosed with Depression in the past 2 years?	**NO**	**YES**
Have you been on an antidepressant medication in the past 2 years?	**NO**	**YES**
Over the last 2 weeks have you often been bothered by any of the following problems?		
1) Little interest or pleasure in doing things? (This question asks if you are so depressed that things you normally enjoy doing you no longer want to do)	**NO**	**YES**
2) Feeling down, depressed, or hopeless?	**NO**	**YES**

STOP: Do not fill out the bottom section if answers to sections above are NO

		Not at all	Several days	More than half the days	Nearly every day
1)	Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2)	Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
3)	Trouble falling or staying asleep or sleeping to much	**0**	**1**	**2**	**3**
4)	Feeling tired or having little energy	**0**	**1**	**2**	**3**
5)	Poor appetite or over eating	**0**	**1**	**2**	**3**
6)	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7)	Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
8)	Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have moving around a lot more than usual	**0**	**1**	**2**	**3**
9)	Thoughts that you would be better off dead, or of hurting yourself in some way	**0**	**1**	**2**	**3**
		add columns:	+	+	
		TOTAL			

10)	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult