# Stormont-Vail Health*Care* & Cotton-O'Neil Clinic

Patient Medical Questionnaire

**Name:** _____ **Birthdate:** _____ **Today's Date:** _____

**Primary Care Physician:** _____

**Reason for visit (circle):** New Patient / Consult / New Problem _____

**Current or past medical problems (circle):** Asthma / COPD / Allergies / Arthritis / Cancer / Diabetes / Thyroid problems / High Blood Pressure / Heart Disease / High Cholesterol / Menstrual problems / Anxiety / Depression / GERD / Kidney Disease / Seizures / Skin problems / Chicken Pox
Others: _____

**List all medications, doses and prescriber. Include over-the-counter medications or supplements:**

_____ _____

_____ _____

_____ _____

_____ _____

**Allergies or intolerance to medications:**

_____

_____

Please circle:

**Marital Status:** Divorced / Legally Separated / Life Partner / Married / Significant Other / Single / Widowed
**Race** - you may circle 2, but list 1st, then 2nd: - American Indian and Alaskan / Asian / Black or African American / Hispanic / Native Hawaiian or other Pacific Islander / Other / Prefer not to answer / White or Caucasian
**Ethnicity:** Hispanic / Non-Hispanic / Prefer not to answer
**Preferred language:** English or _____

**Tobacco use or exposed to Passive Smoke:** Current everyday smoker / Current some day smoker / Former smoker / Heavy tobacco smoker / Light tobacco smoker / Never smoked / Passive smoke exposure—never smoked
**Smoking tobacco type:** Cigarettes / Pipe / Cigars / E-Cig
How many packs per day: _____ How many years ? _____ Started when? _____
**Smokeless tobacco use:** Current user / Former user / Never used
**Ready to quit?** Yes / No

**Last menstrual cycle** _____ / Post-Menopausal / Pregnant / Breastfeeding Last Pap _____

**Most recent immunizations:** Tetanus _____ Whooping Cough _____
Pneumonia _____ Shingles _____
HPV vaccine (Gardisil) _____ Do you get a flu shot annually? Yes / No
Other Immunizations: _____

**Last Mammogram** _____ **Last Colonoscopy** _____

***Continued on reverse…***

**Prior hospitalization or surgeries — when, where, which surgeon (if you remember)**

_____

_____

_____

**Family History:**

Label sibling or child: sister as S, brother as B, daughter as D, sons as S

Add maternal grandparents as MGM and MGF, paternal grandparents as PGM and PGF

| Name | Alive? | Healthy | Alcoholism | Arthritis | Asthma | Cancer | COPD | Depression | Diabetes | Drug Abuse | Early Death | Heart Disease | High Cholesterol | Hypertension | Kidney Disease | Mental Illness | Stroke | Thyroid Disease | Vision Loss | OTHER | ADHD | Allergic Rhinitis | Anxiety | Dementia | Colon Polyps | GERD | Migraines | Kidney Stones | Things in Family | | |
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| Mother | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Father | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sibling | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sibling | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sibling | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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**Social History:**

Alcohol use — Yes / No Number of: ___ glasses wine per week ___ shots/mixed drinks per week ___ cans beer per week

Drug use: Yes / No If yes, how much per week: ____ which type: marijuana / meth / cocaine / IV / other

**Are you sexually active:** No / Not currently / Yes If yes, with a: Male / Female / Both

Which birth control (circle): Abstinence / Coitus Interruptus / Condom / Diaphragm / Implant (Nexplanon) / Injection (Depo) / IUD / Oral Contraceptive Pills / Patch / Post-Menopause / Rhythm / Spermicide / Surgical / Vasectomy / Tubal / Other / None

**Occupation:** _____ **Employer:** _____

**Currently living with:** Alone / Spouse / Friends / Attendant / Family _____

If there is anything else we need to know that is not covered, please list here.

_____

_____

If you must cancel your appointment, please notify us as soon as possible. We appreciate notification of cancellations with more than 24 hours prior to scheduled appointment; this allows us to schedule other patients who need care. We are obligated to record all cancellations and no-show in your medical record.

Person filling out form if not the patient: _____