Name: Date:

Date of Birth: Age:

Gender: Pronouns:

PATIENT QUESTIONNAIRE

All information provided is confidential and will only be released with your written permission.

Please list all medications you are currently taking. Include all prescription medication, over the counter medication and any vitamins/herbal remedies:

	NAME OF MEDICATION	DOSE	FREQUENCY TAKEN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Any known **ALLERGIES**:

Medication	YES	NO	Animal / Pet	YES	NO
Name of Medication:			Seasonal	YES	NO
Food	YES	NO	Other:		

Please list all previous **SURGERIES**:

	Type of Surgery	Year		Type of Surgery	Year
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Past and Present **MEDICAL HISTORY**:

MEDICAL HISTORY	SELF	FAMILY - RELATIONSHIP
Cancer - What Type:	YES NO	YES NO Who:
Diabetes	YES NO	YES NO Who:
Heart Disease	YES NO	YES NO Who:
High Blood Pressure	YES NO	YES NO Who:
Asthma / Lung Disease	YES NO	YES NO Who:
Seizure / Stroke	YES NO	YES NO Who:
Auto Immune	YES NO	YES NO Who:
Other:	YES NO	YES NO Who:

The following questions are about your **FAMILY.** Please answer to the best of your ability and knowledge.

FAMILY MEMBER	LIVING	DEAD	PRESENT AGE or AGE AT DEATH	HEALTH PROBLEMS Or CAUSE OF DEATH (If Deceased)
MOTHER				
FATHER				
BROTHER				
BROTHER				
BROTHER				
BROTHER				
SISTER				
SISTER				
SISTER				
SISTER				

If applicable, **date or year** of last Colonoscopy: _____

Performed at: _____

Results: _____

Was Follow Up Recommended? _____

SOCIAL HISTORY:

Do you smoke?	No	Yes	Age Started _____	Quit (year) _____
	If Current Smoker or Quit within 12 Months: Cigarettes Cigars Pipe Smokeless Tobacco (Vaping) _____ Packs per Day Week			
Do you drink alcohol?	Never	Occasional	Weekly	Daily
Do you have caffeine daily?	Ex: coffee, pop, tea	No	Yes _____ cups per day	
Do you use recreational drugs?	No	Yes	Specify Type: _____	How often: _____
Do you wear sunscreen?	No	Yes		
Do you wear a seatbelt?	No	Yes		
Do you have an advanced directive or living will?	No	Yes _____		
Do you exercise?	No	Yes	Type of Exercise: _____	Times per week: _____
Your Occupation/Job is:	_____			
Marital Status:	Single	Married/Separated	Divorced	Widowed

FOR WOMEN ONLY:

First day of last menstrual period or date of menopause: _____

Number of pregnancies: _____

Date of most recent pap test: _____

Date of most recent Mammogram: _____ Date of most recent Bone Density:_____

Gynecologist Name: _____

COMMUNITY RESOURCE SCREENING:

In the last 12 months, do you ever worry whether your food would run out before you had money to buy more?	YES	NO
In the last 12 months, has the electric, gas, or water company threatened to shut off your service in your home?	YES	NO
Are you worried that in the next 2 months, you may not have stable housing?	YES	NO
In the last 12 months, have you needed to see a doctor, but could not because of cost?	YES	NO
In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	YES	NO
Do you ever need help reading hospital materials?	YES	NO
Do you often feel that you lack companionship?	YES	NO
Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight.	YES	NO
If you answered YES to any of the above questions, would you like to receive assistance with any of these needs?	YES	NO

PATIENT COMMUNICATIONS (HIPAA)

By Law, without your authorization, Oakland Family Practice cannot communicate your medical information with anyone including spouses, adult children, parents or caregivers.

Oakland Family Practice may at some point need to discuss your healthcare information; this may include but not limited to: diagnosis, medical treatment, appointments, financial information, plans and medical care. Please indicated the names and relationship of the individuals in which we may communicate with:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Date: _____ Patient Signature: _____
(or Guardian, if applicable)