# Patient Health History

Concentra totalcare

Screening ID#: ____

Date: ____ Patient Name: ____

Reason for visit: ____ Specific Health Concern: ____

**Lifestyle Practices:** (Please circle your response or complete field as indicated)

| Question | | | | | |
|---|---|---|---|---|---|
| Do you eat breakfast most days of the week? | No | Yes | | | |
| How many cups of milk or milk products (cheese, yogurt, etc) do you eat per day? | None | 1–2 | 3–4 | >4 | |
| How many fruits and vegetables do you eat on a daily basis? | None | 1–2 | 3–4 | 5–6 | >6 |
| How many sodas do you drink per day on average? | None | 1–2 | 3–4 | 5–6 | >6 |
| Do you take supplements such as Calcium, vitamin D, or folic acid? | No | Yes - please list: | | | |
| How many days per week do you exercise? | None | 1–2 | 3–4 | 5–6 | >6 |
| When exercising, how many minutes do you exercise? | <15 | 15–30 | 31–45 | 46–60 | >60 |
| How many hours per week do you work or study? | <15 | 15–30 | 31–45 | 46–60 | >60 |
| How many hours of sleep on average do you get per night? | <5 | 5 – 6 | 7 – 8 | 9 – 10 | >10 |
| Who lives at home with you? | No one | Spouse/partner | Roommate | | |
| | Parents | Children – ages: | | | |
| Do you use tobacco products? | No | Yes, ____ packs/day | ____ cigars/day | ____ # cans/week | |
| How often did you have a drink containing alcohol (such as beer, wine, cocktail, shot, or wine cooler) in the past year? | Never | <1X/month | 2-4X/month | 2-3X/week | >4X/week |
| How many drinks did you have on a typical day when you were drinking in the past year? | 1-2 | 3-4 | 5-6 | 7-9 | 10 or more |
| How often did you have 6 or more drinks on one occasion in the past year? | Never | < Monthly | Monthly | Weekly | Daily |
| Do you use illicit drugs or medication for non-medical (recreational) use? | No | Yes - if so, what? | | | |
| Do you use seat belts when driving or riding in a car? | No | Yes | | | |
| Do you wear hearing protection when exposed to loud noise? | No | Yes | | | |
| How often do you operate a vehicle after using alcohol-containing drinks? | Never | Sometimes | Regularly | | |
| How often do you use a have or sun screen when spending time outdoors? | Never | Sometimes | Regularly | | |

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**Medical History:** (Please circle your response; If "yes" to any of the following questions, please describe)

| | | |
|---|---|---|
| Do you have a primary care physician whom you see for minor illnesses and regular medical care? | No | Yes |
| For what ongoing medical problems are you currently being treated? | Conditions:<br>Current medications: | |
| When was your last tetanus booster? | I don't know | Date: |
| Did you get a flu shot during the last flu season? | No | Yes |
| Are you allergic to any medications? | No | Yes - please list: |

Did a parent or grandparent have any of the following:

| | | | | | |
|---|---|---|---|---|---|
| a. Heart attack before age 50? | No | Yes | b. Diabetes? | No | Yes |
| c. Stroke before age 65? | No | Yes | d. Glaucoma? | No | Yes |
| e. Ovarian Cancer? | No | Yes | f. Breast Cancer? | No | Yes |
| g. Colo-rectal Cancer? | No | Yes | h. Prostate Cancer? | No | Yes |
| i. Cholesterol? | No | Yes | | | |

Other medical illness in the family?

For women: When was your last mammogram? Last PAP smear? Last menstrual period?

Have you had an abnormal PAP smear in the past 3 years?

**Review of Systems:**

| | | |
|---|---|---|
| Have you recently had unexplained weight gain or loss? | No | Yes, how much gain/loss? |
| Have you had fever, chills or night sweats in the past month? | No | Yes |
| Have you noticed any changes in skin markings, moles or freckles? | No | Yes |
| Have friends, family or co-workers told you have a hearing loss? | No | Yes |
| Do you have problems with toothaches, dental cavities or gum problems? | No | Yes |
| Have you noticed any recent changes in your vision? | No | Yes |
| Do you have any stomach pain or persistent nausea or vomiting? | No | Yes |
| Do you have pain or burning when urinating or blood in your urine? | No | Yes |
| Have you noticed blood in your stool? | No | Yes |
| Have you noticed changes in your bowel movements? | No | Yes |
| Do you have shortness of breath with regular activity or with exercise? | No | Yes, which activity? |
| Do you have chest pain, pressure, or discomfort upon exertion? | No | Yes |
| Have you had problems with high blood pressure? | No | Yes |
| Do you have chest pain or pressure at rest? | No | Yes |
| Are you thirsty more than you think you should be? | No | Yes |
| Do you have to urinate more than you think you should? | No | Yes |
| Do you snore loudly or have you been told that you are a heavy snorer? | No | Yes |
| Do you have problems with daytime sleepiness? | No | Yes |
| Over the past 2 weeks, have you felt down, depressed, or hopeless? | No | Yes |
| Over the past 2 weeks, have you felt little interest or pleasure in doing things? | No | Yes |
| Do you suffer from sleep problems or insomnia? | No | Yes |

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