HEALTH HISTORY QUESTIONNAIRE

Name_(Last, First, MI)_**:**	**DOB:**

ROUTINE SCREENING/IMMUNIZATIONS		
Have you ever had a **Colonoscopy**?	☐No	☐Yes, then… When was the last one done? ______ Who was the doctor? ______ Where was it done? ______
Females: Have you ever had a **Mammogram**?	☐No	☐Yes, then… When was the last one done? ______ Where was it done? ______
Females: Have you ever had a **Pap Smear**?	☐No	☐Yes, then… When was the last one done? ______ Who was the doctor? ______
Have you had **Immunizations** at a pharmacy before?	☐No	☐Yes, then… Which pharmacy? ______

SELECT & LIST ANY MEDICAL PROBLEMS OR CHRONIC ILLNESSES		
☐ ADHD ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Atrial Fibrillation ☐ Blood Clot/DVT ☐ Cancer ☐ COPD ☐ Crohns/IBD ☐ Dementia ☐ Depression ☐ Diabetes ☐ Fibromyalgia	☐ GERD ☐ Heart Attack ☐ Heart Disease ☐ Heart Failure ☐ Hepatitis ☐ High Cholesterol ☐ Hypertension ☐ Kidney Disease ☐ Migraines ☐ Parkinsons ☐ Stroke ☐ Thyroid Disease ☐ Vertigo	**Other:**

PREVIOUS SURGICAL HISTORY		
Year	**Name of Surgery**	**Hospital/ Doctor's Name**

PERSONAL HABITS & LIFESTYLE	
MARITAL STATUS: □Single □Married □Divorced □Widowed □Legally Separated	
WHO DO YOU CURRENTLY LIVE WITH?	□Alone □ Roommate □Mother □Father □Sibling(s) □Significant Other □Spouse □Children □Other:____________
WHAT IS YOUR CURRENT WORK STATUS?	□Employed, Full-Time □Employed, Part-Time □Retired □Unemployed □Disabled
WHAT IS YOUR JOB TITLE?	
ARE YOU FOLLOWING ANY SPECIFIC DIET?	□Healthy/Well-Balanced □Keto □Vegetarian □Diabetic □High Protein □Lactose-Free □Other:___________
HOW MANY TOTAL HOURS OF SLEEP DO YOU GET PER NIGHT?	□Less than 5 Hours □7 Hours □10 Hours □5 Hours □8 Hours □More than 10 Hours □6 Hours □9 Hours
ARE YOU A BLOOD DONOR?	□No □Yes
DO YOU DRIVE?	□No □Yes
HAVE YOU EVER USED ANY OF THE FOLLOWING?	□Cigarettes □E-Cigs □Cigars □Pipes □Tobacco Chew
DO YOU DRINK ALCOHOL?	□No □Rarely □Occasionally/Socially □Daily
ANY SUBSTANCE/DRUG USE?	□No □Former □Currently
DO YOU DRINK ANY OF THE FOLLOWING?	□Regular Coffee □Tea □Pop/Soda □Decaf Coffee □Energy Drinks
DO YOU EXERCISE?	□Never □Rarely □Sporadically □Regularly
HOW OFTEN DO YOU SEE A DENTIST?	□On a regular basis □Not on a regular basis
DO YOU HAVE TATTOOS?	□No □Yes, how many? ____________
DO YOU HAVE PIERCINGS?	□No □Both Ears □Nose □Navel □Other:____________
ARE YOU CURRENTLY SEXUALLY ACTIVE?	□No □Yes, with a… □Male □Female

OTHER SPECIALTIES THAT YOU ARE SEEING		
□ Allergy & Immunology	□ Gastroenterology	□ Otolaryngology/ ENT
□ Cardiology	□ Nephrology	□ Pain Medicine
□ Colon & Rectal Surgery	□ Neurology	□ Psychiatry
□ Dermatology	□ OB/GYN	□ Pulmonary
□ Endocrinology	□ Ophthalmology	□ Rheumatology
□ Hematology/ Oncology	□ Orthopedics	□ Urology
Other:		

PLEASE BRING THIS FORM IN THE ROOM WITH YOU
THANK YOU

Patient Name: ___________________________________

FRANK R. LAURRI, MD & ASSOCIATES PC

We require the following information for the purpose of helping our staff use the most respectful language when addressing you, understanding our population better, and to better serve all of our patients.

Sex at Birth: ☐ Male ☐ Female ☐ Unknown

Preferred Pronouns: ☐ He ☐ She ☐ They ☐ We ☐ Declined to specify

Sexual Orientation:

☐ Straight or heterosexual
☐ Lesbian, gay, or homosexual
☐ Bisexual ☐ Queer
☐ Pansexual ☐ Asexual
☐ Declined to specify

Gender identity:

☐ Male ☐ Female
☐ Transgender male
☐ Transgender female
☐ Neither exclusively male or female
☐ Declined to specify

1. What is your living situation today?

☐ I have a steady place to live
☐ I have a place to live today, but I am worried about losing it in the future
☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living in a car, abandoned building, bus or train station, or in a park)

2. Think about the place you live. Do you have problems with any of the following?

☐ Pests such as bugs, ants, or mice
☐ Mold
☐ Lead paint or pipes
☐ Lack of heat
☐ Oven or stove not working
☐ Smoke detectors missing or not working
☐ Water leaks
☐ None of the above

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

☐ Often true ☐ Sometimes true ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

☐ Often true ☐ Sometimes true ☐ Never true

5. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

☐ Yes ☐ No

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

☐ Yes ☐ No ☐ Already shut off

7. How often does anyone, including family and friends, physically hurt you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

8. How often does anyone, including family and friends, insult or talk down to you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

9. How often does anyone, including family and friends, threaten you with harm?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

10. How often does anyone, including family and friends, scream or curse at you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

See Back ➡

1. Have you ever felt that you ought to cut down on your drinking or drug use?

☐ Yes ☐ No

2. Have people annoyed you by criticizing your drinking or drug use?

☐ Yes ☐ No

3. Have you ever felt bad or guilty about your drinking or drug use?

☐ Yes ☐ No

4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

☐ Yes ☐ No

Over the last 2 weeks, how often have you been bothered by any of the following problems?				
	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
***Only if you answered "Not at All" to both of the two questions above**, please do **not** answer the questions below. Please bring this form into the exam room.				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed, Or the opposite,- Being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				
If you choose 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? Please circle.	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Please bring the completed form into the exam room.