Martin's Point

Health History Questionnaire

Thank you for choosing Martin's Point to be your partner in health. To help us give you the highest-quality care, please answer the questions on this form as well as you can. Please bring the completed form with you to your appointment. Your provider may ask some follow-up questions when entering this information into your medical record.

If you are unsure of an answer, please write in a question mark ("?"). If the question does not apply to you, please write in "N/A." You may also add more information in the margins, if needed. Thank you!

Patient Information

Last name: **Middle:** **First name:**

Preferred name: **Sex assigned at birth** (See Gender Identity section for additional options)**:**

Date of birth: / / **Social Security number:**

Address: Street:

City: State: Zip Code:

Phone numbers: Home: Mobile: Work:

Email address:

How do you prefer we contact you? ☐ Home phone ☐ Work phone ☐ Mobile phone ☐ Mail

Usual provider:

Language: **Race:** *(Examples: White, Black or African American, Asian, etc.)* **Ethnicity:** *(Examples: French, Italian, Mexican, Puerto Rican, Chinese, etc.)* ☐ Refused

How did you hear about us?

☐ Advertising ☐ Primary care physician ☐ Specialist physician

☐ Word of mouth ☐ Patient in practice ☐ Hospital

☐ Insurance company ☐ Other (specify):

Medications and Allergies

Are you currently taking any prescribed or over-the-counter medication(s)? ☐ No ☐ Yes

(If yes, please list your medication information below—or bring your medication list to your appointment.)

Medication name:	Dose (mg):	How do you take your medication?	Date Started:
1		☐ By mouth ☐ Other	
2		☐ By mouth ☐ Other	
3		☐ By mouth ☐ Other	
4		☐ By mouth ☐ Other	
5		☐ By mouth ☐ Other	
6		☐ By mouth ☐ Other	
7		☐ By mouth ☐ Other	
8		☐ By mouth ☐ Other	
9		☐ By mouth ☐ Other	
10		☐ By mouth ☐ Other	

Do you have any allergies? ☐ No ☐ Yes

(If yes, please list allergy information below.)

Allergy:	Last time you had a reaction? Date:	Symptom(s) experienced:
1		
2		
3		
4		
5		
6		

Family History

Do any of your biological family members have any diseases/conditions? ☐ No ☐ Yes

(If yes, list disease(s)/condition(s) information below.)

Check disease (if applicable):	Relation to patient:	Age of family member when disease began:	If disease was terminal, age of family member at time of death:
☐ Alcoholism			
☐ Alzheimer's disease			
☐ Asthma			
☐ Stroke			

Check disease (if applicable):	Relation to patient:	Age of family member when disease began:	If disease was terminal, age of family member at time of death:
☐ COPD			
☐ Coronary artery disease			
☐ Dementia			
☐ Diabetes			
☐ Disorder of endocrine system			
☐ Glaucoma			
☐ High cholesterol			
☐ High blood pressure			
☐ Kidney disease			
☐ Melanoma			
☐ Breast cancer			
☐ Colon cancer			
☐ Lung cancer			

Social History

Substance Use

Do you or have you ever smoked tobacco?

- ☐ Never smoked
- ☐ Former smoker
- ☐ Currently smoke every day
- ☐ Currently smoke some days

If yes:

How many years have you smoked tobacco?

At what age did you start smoking tobacco?

Do you or have you ever used any other forms of tobacco or nicotine? ☐ No ☐ Yes

Do you or have you ever used e-cigarettes or vape? ☐ Never ☐ Former User ☐ Current User

What is your level of alcohol consumption?

- ☐ None
- ☐ Occasional
  Women: Less than 1 drink a day
  Men: Less than 2 drinks a day
- ☐ Moderate
  Women: 1 drink a day
  Men: 2 drinks a day
- ☐ Heavy
  All: 5+ drinks on same occasion, at least 5 times in the last month

Do you use any illicit or recreational drugs? ☐ No ☐ Yes

If yes:

Which illicit or recreational drugs have you used?

How many years have you used illicit or recreational drugs?

Caffeine intake:

- ☐ None
- ☐ Occasional
  Less than 1 caffeinated drink a day
- ☐ Moderate
  1–2 caffeinated drinks a day
- ☐ Heavy
  More than 2 caffeinated drinks a day

Home and Environment

Have there been any changes to your family or social situation? ☐ No ☐ Yes

Do you have smoke and carbon monoxide detectors in your home? ☐ No ☐ Yes

Are you passively exposed to smoke? ☐ No ☐ Yes

Are there any guns present in your home? ☐ No ☐ Yes

What is the fluoride status of your home? ☐ Flouridated ☐ Non-Flouridated ☐ Unknown

Do you use insect repellent routinely? ☐ No ☐ Yes

Do you use sunscreen routinely? ☐ No ☐ Yes

Education and Occupation

What is the *highest grade or level of school* you have completed or the highest degree you have received?

☐ Never attended/kindergarten only ☐ Less than Grade 8 ☐ Grade 8 ☐ Grade 9
☐ Grade 10 ☐ Grade 11 ☐ Grade 12, no diploma
☐ GED or equivalent ☐ High school graduate ☐ Some college, no degree
☐ Associate degree: occupational, technical, or vocational program
☐ Associate degree: academic program
☐ Bachelor's degree (e.g., BA, BS, etc.) ☐ Master's degree (e.g., MA, MS, MBA, etc.)
☐ Professional school degree (e.g., MD, DDS, etc.) ☐ Doctoral degree (e.g., PhD, etc.)
☐ Don't know

Occupation:

Marriage and Sexuality

What is your relationship status? ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner ☐ Other

Are you sexually active? ☐ No ☐ Yes

Do you use protection during sex? *(Example: condoms or dams)* ☐ Always ☐ Usually ☐ Never

How many children do you have?

Activities of Daily Living

Are you blind or do you have difficulty seeing? ☐ No ☐ Yes

Are you deaf or do you have serious difficulty hearing? ☐ No ☐ Yes

Do you have difficulty concentrating, remembering, or making decisions? ☐ No ☐ Yes

Do you have difficulty walking or climbing stairs? ☐ No ☐ Yes

Do you have difficulty dressing or bathing? ☐ No ☐ Yes

Do you have difficulty doing errands alone? ☐ No ☐ Yes

Lifestyle

Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)?

☐ Not at all ☐ Only a little ☐ To some extent ☐ Rather much ☐ Very much

Do you use your seat belt or car seat routinely? ☐ No ☐ Yes

Diet and Exercise

What type of diet are you following? ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten-free ☐ Carbohydrate ☐ Cardiac ☐ Diabetic ☐ Specific

What is your exercise level? ☐ Occasional ☐ Moderate ☐ Heavy

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?

What types of sporting activities do you participate in?

Hobbies/ activities:

Advanced Directive:

Do you have an advanced directive? ☐ No ☐ Yes

Medical Wellness Visit/IPPE:

How confident are you that you can manage most of your health problems?

☐ Very confident ☐ Somewhat confident ☐ Not very confident

☐ I don't have any health problems

Gender Identity and LGBTQ Identity:

Gender identity:

☐ Male ☐ Female

☐ Transgender Male/Female-to-Male (FTM)

☐ Transgender Female/Male-to-Female (MTF)

☐ Gender non-conforming (neither exclusively male or female)

☐ Other, please specify:

Assigned sex at birth: ☐ Male ☐ Female

Pronouns: ☐ He/him ☐ She/her ☐ They/them

First name used:

Sexual orientation:

☐ Lesbian, gay, or homosexual ☐ Straight or heterosexual ☐ Bisexual

☐ Other, please describe:

☐ Don't know ☐ Choose not to disclose

Surgical History

Have you had any previous surgeries? ☐ No ☐ Yes

(If yes, list surgery information below.)

Check surgery (if applicable):

- ☐ Ablation (cardiac)
- ☐ Ablation (endometrial)
- ☐ Ablation (venous)
- ☐ Amputation
- ☐ Appendectomy
- ☐ Arthroscopic surgery
- ☐ Back surgery
- ☐ Breast augmentation
- ☐ Coronary angioplasty
- ☐ Coronary angioplasty with stent
- ☐ Cataract surgery
- ☐ Cesarean section
- ☐ Gall bladder surgery
- ☐ Circumcision
- ☐ Cleft palate/lip repair
- ☐ Colposcopy
- ☐ Coronary artery bypass (CABG)
- ☐ D & C
- ☐ Ear/myringotomy tube placement
- ☐ Eye surgery
- ☐ Frenulectomy
- ☐ Bariatric surgery
- ☐ Gastric surgery
- ☐ Gastrostomy tube replacement
- ☐ Joint replacement
- ☐ Knee surgery
- ☐ LEEP
- ☐ Labial adhesions surgery
- ☐ Lumpectomy
- ☐ Mastectomy (complete)
- ☐ Mastectomy (partial)
- ☐ Neck surgery
- ☐ Neurosurgery
- ☐ Nissen fundoplication
- ☐ Oophorectomy
- ☐ Orthopaedic surgery
- ☐ Other
- ☐ Pacer/AICD placement
- ☐ Prostate surgery
- ☐ Prostatectomy
- ☐ Pyloric stenosis repair
- ☐ Reconstructive surgery
- ☐ Rhinoplasty
- ☐ Septoplasty
- ☐ Splenectomy
- ☐ Strabismus surgery
- ☐ Thyroid surgery
- ☐ Tonsils/adenoid
- ☐ Tracheostomy
- ☐ Tubal ligation
- ☐ Undescended testicle surgery
- ☐ VP shunt placement
- ☐ Valve replacement
- ☐ Vasectomy

Past Medical History

Have you had any past medical issues or conditions? ☐ No ☐ Yes

(If yes, list any past medical issue or condition information below.)

Check medical issue/condition (if applicable):

- ☐ ADD/ADHD
- ☐ Acne
- ☐ Alcohol/drug abuse
- ☐ Allergy (hay fever)
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis (osteoarthritis)
- ☐ Arthritis (rheumatoid)
- ☐ Asthma
- ☐ Autism
- ☐ Blood clot (leg)
- ☐ Blood clot (lung)
- ☐ Blood transfusion
- ☐ Breast lump (benign)
- ☐ Cancer (breast)
- ☐ Cancer (cervical)
- ☐ Cancer (colon)
- ☐ Cancer (other type)
- ☐ Cancer (ovarian)
- ☐ Cancer (skin)
- ☐ Colon polyp
- ☐ Concussion
- ☐ Constipation
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes type 1
- ☐ Diabetes type 2
- ☐ Diverticulosis
- ☐ Emphysema/COPD
- ☐ Fractures (broken bones)
- ☐ GERD/heartburn
- ☐ Gallbladder disease
- ☐ Glaucoma
- ☐ Gout
- ☐ Gynecological condition (endometriosis)
- ☐ Gynecological condition (fibroids)
- ☐ Gynecological condition (other)
- ☐ Headaches
- ☐ Heart murmur
- ☐ Hepatitis (other)
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hip fracture
- ☐ Irritable bowel syndrome
- ☐ Kidney disease/failure
- ☐ Kidney stones
- ☐ Liver disease
- ☐ MRSA infection
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Prostate enlargement
- ☐ Recurrent ear infections
- ☐ Seizure/epilepsy
- ☐ Skin condition (abnormal moles)
- ☐ Skin condition (eczema)
- ☐ Skin condition (psoriasis)
- ☐ Sleep apnea
- ☐ Stomach ulcer
- ☐ Stool incontinence
- ☐ Stroke
- ☐ Thyroid (hyper)
- ☐ Thyroid (hypo)
- ☐ Thyroid (nodule)
- ☐ Urinary tract infections (UTI)
- ☐ Urinary (frequency)
- ☐ Urinary incontinence