Sutter Health

Name _____ Date _____

Comprehensive Adult **Established Patient** Health History Update **Questionnaire**

This is an update form to let us know of any care given by other providers and any changes in your health or status since your last screening exam. Please fill out both pages. If you are uncomfortable with any question do not answer it. Thank-you!

Main reason for today's visit: Preventative Visit (Health Maintenance Exam)

Other concerns: _____

What are your health goals for the next year? _____

How would you rate your health? (circle one): Excellent / Good / Fair / Poor

Please list healthcare providers & their specialty that you see regularly: _____

MEDICAL/SURGICAL HISTORY: Any major medical illnesses or surgeries since your last screening exam at our clinic? □ **NO**
(List here): _____

FAMILY HISTORY UPDATE: Any NEW medical illnesses or deaths in your immediate family since your last screening visit? □ **NO**
(List here): _____

HEALTH ISSUES:

Tobacco Use:

□ Never
Smoke or smoked cigarettes/ pipe/ cigars (circle)? □ Yes
Exposure to second hand smoke? □ No □ Yes

(If never used any tobacco can skip to Alcohol Use section below)

Current smoker: Packs/day: _____ # of years: _____

Former smoker: Quit date: _____

Approximately how many packs/day did you smoke? _____

How many years did you smoke? _____

Other tobacco? (circle) Snuff or Chew
Quit date _____ Currently use? □ Yes

Are you ready to quit? □ No □ Yes

Alcohol Use:

Do you drink alcohol? □ No □ Yes

# of drinks/week: _____ □ Beer □ Wine □ Liquor
How many times in a year have you had >3 drinks (for women) >4 drinks (for men) in a day? _____

Drug Use:

Have you ever used recreational drugs? □ No □ Yes
If yes, which ones? _____
Quit which ones? □ All _____
Any used currently? _____

Please continue to next column on right

Sexual Activity:

Are you sexually involved: □ Not currently □ Never □ Yes
Sexual partner(s) is/are/have been/may be in future:
□ male □ female
Birth control method or STD prevention (check all that apply):
□ None needed □ Condom □ Pill □ IUD □ Patch □ Ring
□ Diaphragm □ Vasectomy □ Tubal ligation
□ Other method
(specify):_____

Other (ADL):

Military Service? □ No □ Yes
Blood Transfusion? □ No □ Yes
Exposure to toxic chemicals at work? □ No □ Yes
Exposure to toxic chemicals doing hobbies? □ No □ Yes

Diet:

Do you follow a special diet? □ No □ Yes
(circle) vegetarian, vegan, gluten free, ✕other
_____

Exercise: Do you exercise regularly? □ Yes □ No
If yes, what kind of exercise? _____

How long (minutes)? _____ How often? _____
Do you use a helmet for recreational activities?
(e.g. bike, skateboard, ski) □ Not applicable □ Yes □ No

Do you use seatbelts consistently? □ Yes □ No

In the past 2 weeks: Have you been feeling down, depressed or hopeless? □ No □ Yes

Do you have little interest or pleasure in doing things? □ No □ Yes

SAFETY:

Does your home have a working smoke detector? □ Yes □ No

Do you have guns in your home? □ No □ Yes

If yes, are they locked up & ammo stored separately? □ Yes □ No

Have you or any family members ever been hurt, insulted, threatened or screamed at? □ No □ Yes

SOCIAL DOCUMENTATION:

Name you prefer we use when contacting you (nickname, first, or last with Mr, Mrs, Ms, etc): _____

Country of birth: _____

Who lives at home with you: □ No one □ Spouse/partner □ Children _____

□ Pets (what type) _____ □ Other (roommates, extended family, etc) _____

Please list your interests, hobbies, group involvement, volunteer work, and/or travel outside of country in the past 6 months:

_____

_____

SOCIOECONOMIC:

Occupation (or prior occupation): _____ Employer: _____

If you are not currently working, you are: □ retired □ unemployed □ on a leave of absence □ disabled □ homemaker

□ other _____

Marital status: □ single □ partner □ married □ divorced □ widowed

Spouse/partner's name: _____

Number of children: _____ Ages (if minors): _____ # of grandchildren: _____ # of great grandchildren: _____

Education: □ high school or GED □ trade school □ college □ graduate school □ other _____

MEDICAL FORMS:

Please check any of the following forms you have completed:

- □ Advance Directive for Health Care (ADHC)
- □ Durable Power of Attorney (DPA) for healthcare decisions
- □ Living Will
- □ POLST (Physician Orders for Life Sustaining Therapy)
- □ Know about these or have the forms but have not completed them
- □ Don't know what these are

WOMEN'S HEALTH HISTORY:

Any pregnancies since your last visit? □ No □ Yes

Total # of pregnancies ever: _____ # of total births: _____

Do you have concerns about your periods or menopause you'd like to discuss? □ No □ Yes

If you are having periods, how often do they occur? Every _____ days. How long do they last? _____ days.

HEALTH MAINTENANCE:

Any new medication allergies, immunizations or studies done outside our clinic (e.g. flu vaccine, mammogram, colonoscopy, etc)?

_____

_____

_____

_____

Thank-you for taking the time to complete this form