deckerville Healthcare Services

2433 BLACK RIVER ST.
DECKERVILLE, MI 48427
PHONE: 810.376.2885
FAX: 810.376.8301
DECKERVILLEHOSP.ORG

Patient Sticker

NEW PATIENT HEALTH QUESTIONNAIRE

Today's Date: _____

Name: _____ **Date of Birth:** _____ **Gender**: ☐ Male ☐ Female

Previous Primary Care Physician: _____ **Reason for Changing:** _____

Allergies (medical, environmental, food): _____

Do you have any problems with hearing, vision, speech, or reading? ☐ No ☐ Yes,_____

CURRENT MEDICATIONS – Include over-the-counter medications and supplements.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICAL CONDITIONS/DIAGNOSIS – Have you ever had or been diagnosed with the following?

☐ Allergies/Hay fever
☐ Atrial fibrillation (A. Fib)
☐ ADD/ADHD
☐ Alzheimer's/Dementia
☐ Anemia/Blood disorder
☐ Arthritis
☐ Asthma
☐ Anxiety/Depression
☐ Bipolar depression
☐ Cancer
☐ Cataracts/Glaucoma
☐ Chronic back pain
☐ Colon polyps
☐ COPD
☐ Coronary Artery Disease
☐ Diabetes
☐ Diabetic retinopathy
☐ Diverticulosis
☐ Eczema/Psoriasis
☐ Fibromyalgia
☐ Glaucoma
☐ Gallbladder disease
☐ GERD/Reflux
☐ Head injury/Concussion
☐ Heart murmur
☐ Hepatitis A, B, or C
☐ High blood pressure
☐ Hemorrhoids
☐ High cholesterol
☐ Irritable Bowel Syndrome
☐ Kidney Disease
☐ Kidney stones
☐ Liver Disease/Cirrhosis
☐ Migraine headaches
☐ Multiple Sclerosis
☐ Neuropathy
☐ Osteoporosis
☐ Peripheral Vascular Disease
☐ Pneumonia
☐ Seizures/Epilepsy
☐ Sleep apnea
☐ Stroke/TIA
☐ STD/HIV
☐ Thyroid Disease
☐ Other _____

Other medical diagnosis not mentioned above: _____

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SURGICAL HISTORY – Please list approximate date or age at time of surgery if known.

☐ Appendectomy
☐ Bariatric Surgery/Lap Band
☐ Bladder Surgery/Repair
☐ Bowel Resection
☐ Brain Surgery
☐ Breast Surgery/Biopsy
☐ Cardiac catheterization
☐ Colonoscopy
☐ Gallbladder Removal
☐ Heart Surgery/Bypass
☐ Hernia Repair
☐ Hysterectomy
☐ Joint Replacement
☐ Organ Transplant
☐ Orthopedic Surgery
☐ Prostate Surgery
☐ Tonsillectomy
☐ Vascular Surgery
☐ Other _____
☐ Other _____
☐ Other _____

Please list any specialists (and location) that you currently receive care from: _____

_____

RECENT PHYSICIAN VISITS/TESTING/PREVENTATIVE CARE – Please provide test results and location if known.

☐ Emergency Room Visit _____
☐ Hospitalization _____
☐ Eye Exam _____
☐ Dental Exam _____
☐ Bone Density _____
☐ Chest X-ray _____
☐ Blood Transfusion _____
☐ MRI _____
☐ Sleep Study _____
☐ Colon Cancer Screening _____
☐ Mammogram _____
☐ PAP smear _____
☐ PSA level/Prostate exam _____
☐ Cholesterol _____
☐ Labs _____
☐ Other _____

IMMUNIZATIONS – Please list date of last vaccine if known.

☐ Child is up-to-date with recommended vaccinations

☐ Influenza
☐ Tetanus
☐ Pneumonia
☐ Hepatitis A
☐ Hepatitis B
☐ HPV
☐ MMR
☐ Shingles
☐ Other _____

GYNECOLOGICAL/OBSTETRICAL HISTORY – Women only.

Age of first period: _____
Age of menopause: _____
Any problems with menopause (i.e. hot flashes, vaginal dryness): _____
History of hormone replacement therapy? ☐ Yes ☐ No
BRCA gene carrier? ☐ Yes ☐ No ☐ Unknown

Last menstrual period: _____
Total number of pregnancies: _____
Total number of deliveries:_____ Miscarriages: _____
Any complications during pregnancy (i.e., diabetes, pre-eclampsia): _____
_____

PRENATAL/BIRTH HISTORY – Children only.

Birth weight: _____
☐ Vaginal delivery ☐ C-section delivery

Please list any complications during pregnancy or delivery: _____
_____

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FAMILY HISTORY – Blood relatives only. ☐ Unknown family history

Relative	Age	Alive/Deceased *(please circle)*	Health Problems
Mother		alive/deceased	
Father		alive/deceased	
Maternal Grandmother		alive/deceased	
Maternal Grandfather		alive/deceased	
Paternal Grandmother		alive/deceased	
Paternal Grandfather		alive/deceased	
Siblings			
Other significant history			

SOCIAL HISTORY

Tobacco Use: ☐ Current ☐ Former ☐ Never
(circle) Cigarette/Cigar/Pipe/Chewing Tobacco
Amt/day _____ # Years _____ Date Quit_____
Alcohol Use: ☐ Yes ☐ No ☐ History of alcohol abuse
(circle) Beer/Wine/Liquor Average # drinks/week: _____
Recreational Drug Use: ☐ Current ☐ Former ☐ Never
If yes, what type and how often: _____
Do you use medical marijuana? ☐ Yes ☐ No

Regular Exercise: ☐ No ☐ Yes, _____ minutes per week
Do you follow a special diet? ☐ No ☐ Yes _____
Caffeine: *(circle)* Coffee/Tea/Soda #cups/day _____

Marital Status:
☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Child
Whom do you live with?
☐ Alone ☐ Partner ☐ Family ☐ Other _____
Do you feel safe at home? ☐ Yes ☐ No
Are you able to meet all your own personal needs?
☐ Yes ☐ No, I need help with: _____

Do you have a Living Will/Durable Power of Attorney?
☐ Yes ☐ No ☐ Copy on file with Deckerville Hospital

Occupation: ☐_____ ☐ Retired ☐ Disabled
If disabled, describe nature of disability:
_____
☐ Exposure to toxic chemicals at work.
☐ Exposure to toxic chemicals doing hobbies.
☐ Military Service _____

Sexual Activity:
Are you currently in a sexual relationship? ☐ Yes ☐ No
Number of lifetime partners: _____
Current method of birth control method/STD prevention (*check all that apply):* ☐ None ☐ Condom ☐ Pill ☐ IUD ☐ Patch ☐ Ring ☐ Vasectomy ☐ Tubal Ligation ☐ Other:_____

Do you wear a seatbelt consistently? ☐ Yes ☐ No
Do you wear protective equipment for recreational activities/sports (i.e. helmet, elbow pads) ☐ Yes ☐ No

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REVIEW OF SYSTEMS –Are you currently experiencing any of these symptoms? Please check all that apply.

General
- ☐ Fatigue
- ☐ Fever/chills
- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Loss of appetite

Ear/Nose/Throat
- ☐ Hearing loss
- ☐ Earache
- ☐ Nosebleeds
- ☐ Runny nose
- ☐ Sinus problems/congestion
- ☐ Mouth sores
- ☐ Trouble swallowing/choking
- ☐ Sore throat
- ☐ Hoarseness/change in voice
- ☐ Bleeding gums
- ☐ Dental problems/toothache

Eyes
- ☐ Eye redness
- ☐ Drainage from the eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Eye injury

Respiratory
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Chest tightness
- ☐ Cough
- ☐ Chest congestion

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ Swelling feet, ankles, or hands
- ☐ Difficulty breathing at night
- ☐ Short of breath when lying flat
- ☐ Activity intolerance
- ☐ Varicose veins
- ☐ Passing out/syncope

Gastrointestinal
- ☐ Change in bowel patterns
- ☐ Painful bowel movement
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn/reflux
- ☐ Abdominal pain
- ☐ Rectal bleeding/blood in stool
- ☐ Black or tarry stools

Genitourinary
- ☐ Frequent urination
- ☐ Pain or burning with urination
- ☐ Incontinence
- ☐ Blood in urine
- ☐ Sexual difficulties
- ☐ Testicular pain/lump(s)
- ☐ Severe menstrual cramping
- ☐ Irregular menstrual periods
- ☐ Heavy menstrual periods

Musculoskeletal
- ☐ Joint pain/stiffness
- ☐ Muscle pain/cramping
- ☐ Abnormally cold hands/feet
- ☐ Back pain
- ☐ Difficulty walking

Skin/Breast
- ☐ Rashes or itching
- ☐ Change in skin color
- ☐ Concerning moles/sores
- ☐ Breast pain/lumps
- ☐ Nipple discharge

Neurological
- ☐ Frequent/Recurring headache
- ☐ Light headedness/dizziness
- ☐ Convulsions, seizures or spasm
- ☐ Numbness or tingling
- ☐ Tremors
- ☐ Paralysis
- ☐ Stroke
- ☐ Head injury
- ☐ Memory problems

Psychiatric
- ☐ Nervous
- ☐ Insomnia
- ☐ Depression

Endocrine
- ☐ Heat or cold intolerance
- ☐ Excessive skin dryness
- ☐ Excessive thirst or urination
- ☐ Excessive sweating

Hematologic/Lymphatic
- ☐ Unusual bleeding or bruising
- ☐ Swollen glands