

# Amethyst Medical Group Health Questionnaire and Intake Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ How did you hear about us: \_\_\_\_\_

**1. PAST MEDICAL HISTORY:** Have you ever had (circle No or Yes) and specify at bottom of section

Diabetes.....No	Yes	Recurrent or Severe Infection.....No	Yes
Stroke.....No	Yes	Rheumatic Fever.....No	Yes
Cancer.....No	Yes	Tuberculosis.....No	Yes
High Blood Pressure.....No	Yes	Hepatitis (ABC, please specify).....No	Yes
Heart Problems .....No	Yes	Anemia.....No	Yes
Myocardial infarction.....No	Yes	Blood Transfusion.....No	Yes
Arthritis.....No	Yes	Autoimmune/Immunosuppressive disorder.....No	Yes
Osteoporosis.....No	Yes		

Have you had, or do you have presently, any other serious illness or chronic medical condition that we should be aware of?                      No      Yes

If yes, describe \_\_\_\_\_

Have you ever been hospitalized or been under medical care for any period?      No      Yes

If yes, for what reason? \_\_\_\_\_

***Injuries:***

Have you had any broken bones?.....No Yes

If yes, briefly describe \_\_\_\_\_

Have you had any head concussions or injuries?.....No Yes

If yes, briefly describe \_\_\_\_\_

Have you had any auto accidents?.....No Yes

If yes, briefly describe \_\_\_\_\_

**2. PAST SURGICAL HISTORY:** Have you had any surgery? No Yes **If yes, list all procedures and approximate dates of surgeries (use back page if needed)**

1. \_\_\_\_\_ Date: \_\_\_\_\_

2. \_\_\_\_\_ Date: \_\_\_\_\_

3. \_\_\_\_\_ Date: \_\_\_\_\_

4. \_\_\_\_\_ Date: \_\_\_\_\_

5. \_\_\_\_\_ Date: \_\_\_\_\_

**3. SOCIAL HISTORY:**

Living situation: Live alone: \_\_\_\_\_ or with \_\_\_\_\_

Do you now, or have you ever, smoked? If so explain: \_\_\_\_\_

How much alcohol do you drink and how often? \_\_\_\_\_

Do you have any history of illegal/prescription drug abuse? \_\_\_\_\_

Where were you born?: \_\_\_\_\_

What is your highest level of education? \_\_\_\_\_

What is your current/previous occupation? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

What do you do for exercise? \_\_\_\_\_

What is your diet like? \_\_\_\_\_

How many caffeinated beverages do you drink? \_\_\_\_\_

List countries have you have visited? \_\_\_\_\_

What is your stress level? High Medium Low, please explain \_\_\_\_\_

Do you have an advance directive? No Yes If yes, may we have a copy?

**4. TOXIC EXPOSURES: Have you had any exposure to toxic substances? No Yes If yes, list all substances and approximate dates of exposure**

1. \_\_\_\_\_ Date: \_\_\_\_\_

2. \_\_\_\_\_ Date: \_\_\_\_\_

3. \_\_\_\_\_ Date: \_\_\_\_\_

4. \_\_\_\_\_ Date: \_\_\_\_\_

5. \_\_\_\_\_ Date: \_\_\_\_\_

**5. FAMILY HISTORY:**

If you are adopted and have no knowledge of your family history, please check this line and proceed to the Section #6 \_\_\_\_\_. Otherwise check all those that apply and indicate if deceased. (For Grandparents, Aunts or Uncles please indicate **P** for paternal or **M** for maternal)

	Father	Mother	Grand-father	Grand-mother	Aunt	Uncle	Brother	Sister	Children
Age (or Age at death)									
Health (G=good, F=fair, P=poor)									
Arthritis									
Asthma									
Back Problems									
Cancer									
Circulatory Problems									
Diabetes									
Emphysema / COPD									
Headaches									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Kidney Disease									
Osteoporosis									
Sinus Problems / Allergies									
Stroke									
Thyroid Problems									
Ulcer or Stomach Problems									
Other									

**6. MEDICATIONS / SUPPLEMENTS:** Please list all current medications and dosages (use back page if needed)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_

4. \_\_\_\_\_

9. \_\_\_\_\_

5. \_\_\_\_\_

10. \_\_\_\_\_

**7. ALLERGIES AND SENSITIVITIES:** Please list any allergies and what type of reaction. If you have NO allergies please check this line \_\_\_\_\_ and proceed to section 8.

***Drug Allergies/Adverse Reactions*** (e.g. sulfa, penicillin, latex, anesthesia medication)

1. \_\_\_\_\_ reaction \_\_\_\_\_

4. \_\_\_\_\_ reaction \_\_\_\_\_

2. \_\_\_\_\_ reaction \_\_\_\_\_

5. \_\_\_\_\_ reaction \_\_\_\_\_

3. \_\_\_\_\_ reaction \_\_\_\_\_

6. \_\_\_\_\_ reaction \_\_\_\_\_

***Seasonal/Environmental allergies*** (e.g. hay fever, perfumes, etc)

1. \_\_\_\_\_ reaction \_\_\_\_\_

4. \_\_\_\_\_ reaction \_\_\_\_\_

2. \_\_\_\_\_ reaction \_\_\_\_\_

5. \_\_\_\_\_ reaction \_\_\_\_\_

3. \_\_\_\_\_ reaction \_\_\_\_\_

6. \_\_\_\_\_ reaction \_\_\_\_\_

***Food Allergies*** (e.g. milk, eggs, chocolate)

1. \_\_\_\_\_ reaction \_\_\_\_\_

4. \_\_\_\_\_ reaction \_\_\_\_\_

2. \_\_\_\_\_ reaction \_\_\_\_\_

5. \_\_\_\_\_ reaction \_\_\_\_\_

3. \_\_\_\_\_ reaction \_\_\_\_\_

6. \_\_\_\_\_ reaction \_\_\_\_\_

**8. IMMUNIZATIONS:** Please fill in the dates of last immunizations. If you prefer to not have immunizations, please indicate.

Tetanus: \_\_\_\_\_

Hepatitis A: \_\_\_\_\_

Pneumonia Vaccine: \_\_\_\_\_

Hepatitis B: \_\_\_\_\_

Flu Vaccine: \_\_\_\_\_

Yellow Fever: \_\_\_\_\_

Zostavax (shingles): \_\_\_\_\_

Other: \_\_\_\_\_

**9. HEALTH MAINTENANCE:** Please fill in dates of last health maintenance procedures

Colonoscopy: \_\_\_\_\_

Bone Density: \_\_\_\_\_

Eye Exam: \_\_\_\_\_

Dental Exam: \_\_\_\_\_

Pap Smear (Females) \_\_\_\_\_

Mammogram: (Females) \_\_\_\_\_

Prostate Exam (Males) \_\_\_\_\_

## 10. REVIEW OF SYSTEMS:

**In the Past 3 months:** Do you have, or have you had, any of the following:

### General:

Have you been in good general health .....No Yes  
 Recent weight loss/gain.....No Yes  
 Sleeping Trouble.....No Yes  
 Fatigue.....No Yes

### Skin:

Acne.....No Yes  
 Rash.....No Yes  
 Dry skin/itching.....No Yes  
 Eczema.....No Yes  
 Sores/growths.....No Yes

### Head-Eyes-Ears-Throat:

Blurry vision/double vision (please specify).....No Yes  
 Cataracts.....No Yes  
 Contact lenses/glasses (please specify).....No Yes  
 Dizziness.....No Yes  
 Ear problems (drainage, earache, etc).....No Yes  
 Eye problems (drainage, infection etc).....No Yes  
 Hearing loss.....No Yes  
 Loss of balance.....No Yes  
 Neck stiffness.....No Yes

### Gastrointestinal:

Abdominal pain.....No Yes  
 Appetite change.....No Yes  
 Blood in stool.....No Yes  
 Change in bowel habits.....No Yes  
 Ulcers.....No Yes  
 Constipation.....No Yes  
 Diarrhea.....No Yes  
 Gallbladder problems.....No Yes  
 Indigestion/heartburn.....No Yes  
 Hemorrhoids or piles.....No Yes  
 Nausea/vomiting.....No Yes  
 Rectal bleeding.....No Yes

### Urologic:

Dribbling.....No Yes  
 Urgency.....No Yes  
 Dysuria (pain or burning with urination).....No Yes  
 Frequent urination.....No Yes  
 Incontinence.....No Yes  
 Hematuria (blood in urine).....No Yes  
 History of stones.....No Yes  
 Infection.....No Yes  
 Nocturia (night time urination).....No Yes  
 Stress incontinence.....No Yes  
 Urgency.....No Yes

### Breast:

Discharge.....No Yes  
 Infection.....No Yes  
 Mass/lump.....No Yes

### Cardiac:

Angina.....No Yes  
 Chest pain.....No Yes  
 Murmur.....No Yes  
 Palpitations.....No Yes  
 Shortness of breath.....No Yes  
 Swelling of extremities (arms/legs).....No Yes

### Pulmonary:

Asthma.....No Yes  
 Frequent cough.....No Yes  
 Pain with breathing.....No Yes  
 Wheezing.....No Yes

### Neurological:

Seizures.....No Yes  
 Paralysis.....No Yes  
 Memory loss.....No Yes  
 Loss of consciousness.....No Yes  
 Headaches.....No Yes  
 Dizziness/fainting spells.....No Yes

### Vascular:

Pain in legs with walking.....No Yes  
 Varicose vein.....No Yes  
 Phlebitis.....No Yes  
 Swelling of legs.....No Yes  
 Abnormal bleeding or bruising.....No Yes

### Endocrine:

Hormone therapy.....No Yes  
 Thyroid problems.....No Yes

### Ob-Gyn:

Hot flashes.....No Yes  
 Mood swings.....No Yes  
 Any pain with periods.....No Yes  
 Menopausal.....No Yes  
 (if yes, at what age \_\_\_\_\_)  
 Frequency of periods, every \_\_\_\_\_ days

### Musculoskeletal:

Arthritis.....No Yes  
 Joint pain.....No Yes  
 Joint swelling.....No Yes  
 Other pains.....No Yes

Please include any other information that we should be aware of:

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