NOTCH
Northern Tier Center for Health
Federally Qualified Health Center

Medical History Questionnaire

Name:_____DOB: _____Today's Date: _____

Height: _____ Weight: _____ Previous Primary Care Provider:_____

Other Care Team Provider (e.g. specialist, out of state providers etc.):_____

Advanced Directive:	Yes	No	Don't Know
Do you have an Advanced Directive? *(if yes, please provide a copy)*	☐	☐	☐
Would you like the Health Center to assist you in developing your Advanced Directive?	☐	☐	☐

Please answer the following questions as best you can, your answers are confidential.

Have there been any major changes to your health within the past year?	☐	☐	☐
If yes, please explain: _____			
Do you have any artificial joints, heart valves, implants, or prosthesis?	☐	☐	☐
Have you had surgery, x-ray treatment, or chemotherapy for a tumor, growth, or other condition?	☐	☐	☐
If yes, please explain: _____			
Females Only:			
Are you currently pregnant?	☐	☐	☐
If Yes, Due Date: _____			
Are you currently breast feeding?	☐	☐	

Health History: *Do you currently have, or have you had any of the following? (Check all that apply)*

- ☐ Addiction
- ☐ Anxiety/Panic Disorder/ PTSD
- ☐ Arthritis
- ☐ Asthma or Shortness of Breath
- ☐ Back or Neck Problems
- ☐ Blood Disease or Anemia
- ☐ Bowel Disease or Ulcers
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Loss of Consciousness
- ☐ Memory Loss
- ☐ Bronchitis or Chronic Cough
- ☐ Cancer or Tumor Location: _____
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fractures, Bone/Joint Deformities
- ☐ Gout
- ☐ Eye Trouble, Injury, or Blindness
- ☐ High Cholesterol
- ☐ Seizures
- ☐ Joint Problems
- ☐ Hernia
- ☐ Gynecological Problems
- ☐ Hearing Loss/ Ringing in Ears
- ☐ Heart Disease or Chest Pain
- ☐ High Blood Pressure
- ☐ Prostate Trouble
- ☐ Liver Disease or Hepatitis
- ☐ Neurological Problems
- ☐ Skin Disease
- ☐ Tuberculosis
- ☐ Trouble Sleeping
- ☐ Thyroid Problems
- ☐ Other: _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

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Health Screening: *Please note the date of your last screening/occurrence for the following:*

☐ Colonoscopy Date: _____ ☐ PSA _____

☐ Mammogram Date: _____ ☐ Pap Smear _____

Last Menstrual Period Date: _____

Surgical History:

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Family History: *Has anyone in your immediate history experienced the following?*

	Father	Mother	Sibling	Child
Cancer or Tumor	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Heart Disease / Heart Attack	☐	☐	☐	☐
Mental Health	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐

☐ **I am adopted and do not know my family history**

☐ Father Deceased Date of Death: _____ Cause of Death: _____

☐ Mother Deceased Date of Death: _____ Cause of Death: _____

Social History *(Check all that apply)*

☐ Alcohol Use Amount: _____

☐ Drug Use

☐ Smoker

☐ Former Smoker Estimated Quit Date: _____

☐ Chewing Tobacco

☐ Abuse/Neglect

☐ Employed Occupation: _____

☐ Occupational Injury Details: _____

☐ Retired

☐ Living with Spouse

☐ Living Alone

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Allergies:

Medication Allergies / Reaction	Food, Environmental, Animal Allergies / Reaction

Current Medications:

Medication	Dosage	Frequency	Reason for Medication?

Immunizations:

	Yes	No	Don't Know
Date of Last Tetanus Shot: _____ If unknown, was it in the last 10 years?	☐	☐	☐
Have you ever received the pneumovax pneumonia vaccine?	☐	☐	☐
If yes, date vaccine received: _____			

I understand that, to the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health or medications, I will inform my health care provider immediately. I hereby give my consent to treatment for myself, or the named patient (of whom I am the parent, legal guardian, or foster parent) to the Northern Tier Center for Health.

We set aside time just for you. If you're running late or must change an appointment, please call us as soon as possible. Arriving late may require your provider to reschedule your visit to allow enough time for your care. If you miss an appointment, you may have to wait for another opening. By calling us when you are unable to make your scheduled appointment, we are able to see other patients waiting for an appointment.

_____ _____

Signature of Patient or Guardian Date