Outer Cape
HEALTH SERVICES

ANNUAL HEALTH HISTORY QUESTIONNAIRE

All information you provide is strictly confidential and will become part of your medical record. Please answer the questions to the best of your ability, especially any information that is new or has changed over the past year. You may leave any or all fields blank, but your provider may ask for the information in your office visit. ***Please complete in <u>BLACK ink only</u>.***

Date Completed:_____

DEMOGRAPHICS

Last Name _____ First Name _____ Middle Initial _____

Date of Birth (mm/dd/yyyy) _____

What is your current gender identity? (Check all that apply)

- ☐ Male
- ☐ Female
- ☐ Female-to-Male (FTM)/Transgender Male/Trans Man
- ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Additional Gender Category/(or Other), please specify
- ☐ Decline to Answer, please explain why

_____

What sex were you assigned at birth on your original birth certificate? (Check one)

- ☐ Male
- ☐ Female
- ☐ Decline to Answer, please explain why

_____

Previous Source of Health Care: (Primary Care Provider Name, Facility, Phone Number)

_____

Date of Last Visit? _____

Have you completed and signed a medical record release form for your primary care provider and specialists, including mental health providers? ❑ Yes ❑ No

If not, please complete and sign release forms.

MEDICAL CONDITIONS: Circle any of the following conditions you have had.

Allergies or Asthma	Cholesterol (high)	High Blood Pressure
Acid Reflux/Heartburn	Congestive Heart Failure	Lung Disease
Alcoholism	Depression and/or Anxiety	Stroke
Anemia	Diabetes	Thyroid Disease
Arthritis	Drug or Alcohol Use Disorder	Other (list):
Breast lumps/cysts	Heart Disease	
Cancer (tumors)	Hepatitis	

SURGERIES AND OTHER HOSPITALIZATIONS

Date **Type of surgery / reason** **Name of hospital**

RECENT SCREENINGS (eg, last mammography, pap test, colonoscopy – Please request prior records from the facilities where these were performed)

OTHER DOCTORS AND SPECIALISTS (Patient Care Team)

Specialist Type	Specialist/ Facility		Specialist Type	Specialist/ Facility
Dental			**Gyn/OB**	
Eye Doctor			**Podiatry**	
Dermatology			**Other**	
Psychiatry (prescriber)			**Other**	
Therapist/Counselor			**Other**	

PRESCRIPTIONS, OVER THE COUNTER MEDICATIONS AND HERBAL PRODUCTS

Name	Dose	Frequency

ALLERGIES TO MEDICATIONS

Medication	Reaction

ALLERGIES TO FOOD AND ENVIRONMENTAL SOURCES

Source	Reaction

SOCIAL HISTORY/HEALTH HABITS AND PERSONAL SAFETY

Occupation: _____

Living Situation: _____

Marital Status ❑ Single ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed

Smoking Have you ever used tobacco?
❑ Current smoker ❑ Former smoker ❑ Never smoker

If yes, how many years have you used tobacco? _____

If yes, year last used? _____

Amount per day: Cigarettes _____ Cigars _____ Vape/Pipe _____ Chew _____

Alcohol

How often did you have a drink containing alcohol in the past year?

❑ Never ❑ Monthly or less ❑ Two to four times a month
❑ Two to three times per week ❑ Four or more times a week

How many drinks containing alcohol did you have on a typical day when you were drinking in the past year? (1 drink = 12 oz. beer, 4 oz wine, 1.5 oz spirits)

❑ 0 drinks ❑ 1 or 2 ❑ 3 or 4 ❑ 5 or 6 ❑ 7 to 9 ❑ 10 or more

How often did you have six or more drinks on one occasion in the past year?

❑ Never ❑ Less than monthly ❑ Monthly ❑ Weekly ❑ Daily or almost daily

Sexual Health

When you were last tested for sexually transmitted infections (STIs)? _____

Have you had any type of sexual contact since the last time you were tested for STIs? ❑ Yes ❑ No

If you have a concern about sexually transmitted infections that you need addressed more urgently, please contact our Sexual Health staff at 774-538-3350

Drugs

Have you ever used recreational or street drugs? ❑ Yes ❑ No

Have you ever misused prescription or non-prescription drugs? ❑ Yes ❑ No

Have you ever given yourself drugs with a needle that was not prescribed to you? ❑ Yes ❑ No

Would you like to meet with a clinician to confidentially discuss your drug use? ❑ Yes ❑ No

Domestic Violence

Have you ever been a victim of verbal, psychological, or physical abuse? ❑ Yes ❑ No

Have you ever felt unsafe or threatened by someone close to you? ❑ Yes ❑ No

Do you feel safe at home? ❑ Yes ❑ No

Diet

List any dietary restrictions:_____

Exercise

What type of exercise do you do? _____

How many times a week? _____ Duration of workout _____

Caffeine Number of cups/drinks per day?

Coffee _____ Soda _____

Tea _____ Energy Drink _____

Mental Health

Have you ever had a psychiatric hospitalization? ❑ Yes ❑ No

Have you ever attempted suicide? ❑ Yes ❑ No

Food Security

In the past 12 months, have you been worried that food would run out before you had money to buy more.

❑ Yes ❑ Sometimes ❑ Never

Women's Health

Are you pregnant? ❑ Yes ❑ No

Date of last period _____ Period every ____ days for ____ days

Are you currently trying to get pregnant? ❑ Yes ❑ No

If no, what is your birth control method? _____

FAMILY MEDICAL HISTORY

❑ Are you **Adopted?** – History Unknown ❑ Yes ❑ No

Family Member	Age	Alive?	If Deceased, cause	Age at Death
Mother				
Father				
Siblings(s)				
Children				
Other				

Thank You for Completing this Form