

Internal Medicine & Pediatric Associates

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Health Questionnaire Update – Established Patient

Please print clearly and update your medical record by completing the following questionnaire.

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Marital Status: Single Married Divorced/ Separated Partnered

Contact Information

Home phone #: _____ Office phone #: _____ Cell phone #: _____

If we need to reach you, how should we contact you? _____

Do you have any special hearing, visual or physical needs: Yes No

If yes, please clarify: _____

Language preference: English If not English, please clarify: _____

In the past year have you had any of the following?

1. Surgeries Yes No If yes, which procedures? _____

2. Emergency Room visits Yes No If yes, for what reason? _____

3. Hospitalizations Yes No If yes, for what reason? _____

4. New medications or allergies Yes No (Please list medication and reaction, if any)

1) _____

2) _____

3) _____

5. Any change in Family Medical History? _____

Risk Assessment/Social History

Do you currently smoke? Yes No If yes, packs per day ____ For how many years? ____

Did you smoke in the past? Yes No If yes, when did you quit? _____

Have you had exposure to smoke now or in the past? Yes No If yes, how many years? ____

Do you drink alcohol? Yes No How many alcoholic beverages do you have in a typical day? ____

Have you used illegal or recreational drugs in the past year? Yes No

How many caffeinated beverages do you have per day? _____

Are you on a special diet (vegetarian, gluten free, etc)? Yes No If yes, specify: _____

Health Questionnaire Update

Established Patient

Patient Name: _____

Date of Birth: _____

How many hours of sleep do you get on a typical night? _____

Do you exercise? Yes No If yes, what type, how often? _____

Do you wear helmets for sports (i.e. biking, lacrosse, skiing, etc.)? Yes No N/A

Do you use a seatbelt? Yes No

Do you have smoke detectors in your home? Yes No

Do you have carbon monoxide detectors in your home? Yes No

Are there firearms in your home? Yes No If yes, are they locked? Yes No

What is your gender identity? Female Male Other: _____

What is your preferred pronoun? He/him She/her They/them Other: _____

Describe your sexual orientation: Heterosexual Homosexual Bisexual Other: _____

Do you use contraception if you are sexually active? Yes No N/A

Do you practice safe sex if you are sexually active? Yes No N/A

Have you ever been a victim of abuse? Yes No When: _____

Have you often been bothered by feeling down, depressed, hopeless, or anxious? Yes No

Do you have a Health Care Proxy? Yes No

Do you have a Living Will? Yes No

Do you have other Health Care Providers?

Provider Name and address

Dentist No Yes _____

Eye doctor No Yes _____

Mental health No Yes _____

OB-GYN No Yes _____

Other _____

Please make suggestions as to how we might better meet your needs.

Thank you for taking the time to complete this form.

Internal Medicine & Pediatric Associates Office Use Only

Reviewed by: _____ Date: _____