Internal Medicine & Pediatric Associates

Tony G. Karem, MD | Spencer R. Idstein, MD | Nicole B. Strecker, MD

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: _____