NAME:
MRN:

KAISER PERMANENTE®

Health Questionnaire

Welcome!

I'm Dr. Ailinh Tran and I am thrilled to be your doctor today.
Please fill out <u>BOTH SIDES</u> of this questionnaire so we can provide you better care.
If you have met me before, please fill out at least the first 3 questions.
Thank you for your time and I look forward to seeing you!

What would you like to make sure we talk about during your visit today?

_____

_____

_____

In the 3 months, were you bothered by the following symptoms?

	Yes	No		Yes	No		Yes	No
Weight gain/loss			Shortness of breath			Joint pain		
Fevers/chills			Abdominal Pain			Vertigo/dizziness		
Excessive Fatigue			Nausea/Vomiting			Trouble sleeping		
Blurry/double Vision			Diarrhea/Constipation			Depression		
Headaches			Blood in stool			Anxiety		
Chest pain			Problems peeing			Stress		

Social History
Occupation:_____
Hobbies: _____
Marital/Relationship Status: _____
If you have children, please list their ages: _____

Do you take any medications regularly? ☐Yes ☐No
Please include any OTC (over the counter) medications, vitamins and herbs
If yes, please list them. Provide dosage information when possible:_____

_____

_____

Please list any medical problems or past medical history or hospitalizations:

_____

_____

Please list any significant past surgeries:

_____

_____

Do you have any allergies to medications? ☐Yes ☐No
If yes, please list them and describe the reaction:_____

Please fill out both sides of this form. Thank you!

Family Medical History

Please check the conditions that are in your family and write the approximate age of diagnosis

	Nobody	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other
Heart Disease								
Diabetes								
High Blood Pressure								
High Cholesterol								
Stroke								
Colon Cancer								
Breast Cancer								
Prostate Cancer								
Other								

Health-Related Behaviors

Have you ever regularly used tobacco (cigarettes, pipe, chewing tobacco)? ☐Yes ☐No

How many cigarettes per day?_____ How many years?___

In the past year, have you had more than 2 alcoholic drinks at one time? ☐Yes ☐No

How many drinks per week? _____

Females: How many times in the past year have you had four or more drinks in a day? _____

Males: How many times in the past year have you had five or more drinks in a day? _____

In the past year, have you used marijuana, Ecstasy, meth, cocaine, or prescription medication , or any other drugs to get high? ☐Yes ☐No

If you are sexually active, do you have sex with men, women or both? ☐Men ☐Women ☐Both

If you are sexually active, do you ever have sex without a condom? ☐Yes ☐No

Do you have concerns about your partner hitting, yelling, or putting you down? ☐Yes ☐No

**If you are being abused, please know that I can help you and provide you with resources and support*

Are you at a healthy weight? ☐Yes ☐No

Do you have healthy eating habits (low fat, limited fast food, etc)? ☐Yes ☐No

Do you exercise at least 3 times a week? ☐Yes ☐No

Do you use sunscreen to protect your skin from the sun? ☐Yes ☐No

Do you take a Calcium/Vitamin D supplement? ☐Yes ☐No

I am new at Kaiser Permanente and I am committed to improving my service to you. Please let me know if there is anything we can do to improve your experience here. What can I do to make it a 5-star day?

_____

_____

Please fill out both sides of this form. Thank you!