Limestone Primary Care
Patient Centered Medical Home

Annual Patient Health Questionnaire

This is a confidential record of your medical history and will be kept in the office. Information contained here will not be released to any person unless you have authorized us to do so.

Name: _____ Date: _____

DOB: _____ Age: _____

General Information

Do you have a living will or an advance directive? Yes ☐ No ☐

If yes, what type? _____

Hospitalizations and Surgeries

List any hospitalizations, surgeries, or procedures you have had performed ***since your last visit***.

What	Date	What	Date

Specialists

List any other doctors involved in your care.

Name	Specialty

Health Maintenance

If you've had a test or vaccine done, ***since your last visit***, list when last performed:

☐ Bone density test: _____
☐ Cholesterol screen: _____
☐ Colonoscopy: _____
☐ Dental exam: _____
☐ Eye exam: _____
☐ Flu Vaccine: _____
☐ Hep B vaccine: _____
☐ HIV testing: _____
☐ HPV vaccine: _____
☐ Mammogram: _____
☐ Meningococcal vaccine: _____
☐ Pap smear: _____
☐ Pneumonia vaccine: _____
☐ Shingles vaccine: _____
☐ Tetanus vaccine: _____

Social History

Do you drink alcohol? ☐ Yes ☐ No
If you answered yes, answer these additional questions:

- What type of alcohol? _____
- How frequently? _____
- Have people annoyed you by criticizing your drinking?
  ☐ Yes ☐ No
- Have you ever felt you should cut down on your drinking?
  ☐ Yes ☐ No
- Have you ever had a drink first thing in the morning to steady your nerves? ☐ Yes ☐ No

Have you ever had a substance abuse problem? ☐ Yes ☐ No
If you answered yes, answer these additional questions:

- What type of drugs do (or did) you use? _____
- How frequently? _____

Have you ever smoked? ☐ Yes ☐ No
If you answered yes, answer these additional questions:

- Do you still smoke? ☐ Yes ☐ No
- How many cigarettes/day? _____
- How many years have you smoked? _____
- If you recently stopped smoking, when did you quit? _____

Is there any history of mental illness (Ex: depression, bipolar, etc.) in your family? ☐ Yes ☐ No

In the last few weeks, have you felt "down", depressed, or hopeless? ☐ Yes ☐ No

Do you feel you have an adequate social life? ☐ Yes ☐ No

Do you feel you have the resources necessary to meet your daily needs? ☐ Yes ☐ No

Marital status: ☐ Single ☐ Married ☐ Dating ☐ Divorced ☐ Widowed
Number of children: _____ **Number of persons in household:** _____

Spiritual orientation: _____

Do you exercise regularly? ☐ Yes ☐ No How often? _____
What type of exercise (e.g. biking, walking, running, swimming, etc.)? _____

Do you eat a healthy diet? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Do you use caffeine on a regular basis? ☐ Yes ☐ No

Do you have any sleeping problems? ☐ Yes ☐ No

Do you have a high level of stress in your life? ☐ Yes ☐ No

Do you lack interest or pleasure in doing things you used to do? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No
Self-described orientation: _____

Use of contraception: ☐ Condoms ☐ Birth control ☐ Other: _____