Today's Date: _____

SCL Health MEDICAL GROUP

COMPREHENSIVE HEALTH ASSESSMENT

Please answer these questions to help us maintain accurate records and provide high quality care. ***All information will be kept confidential and updated annually.*** *Please discuss any questions about these items with your doctor or clinical staff.*

Patient Name: **DOB:**

Reason for Today's Visit: **1)** **2)**

Discussion and/or treatment of medical conditions may result in additional charges from your preventive exam.

Preferred Pharmacy

Name: Location: Number:

Medications

Please list all your MEDICATIONS (*prescriptions, over the counter, vitamins, herbal supplements).* Include the dose and frequency for each.

Drug Name	Dosage	Drug Name	Dosage

Allergies

Allergic To	Reaction	Allergic To	Reaction

Chronic Conditions / Past Medical History

	SELF	FAMILY			SELF	FAMILY	
Migraines	☐	☐	_____	Urinary Tract Infection / UTI	☐	☐	_____
High Blood Pressure	☐	☐	_____	Kidney Disease	☐	☐	_____
High Cholesterol	☐	☐	_____	Kidney Stones	☐	☐	_____
Diabetes	☐	☐	_____	Thyroid Disease	☐	☐	_____
Heart Attack / MI	☐	☐	_____	Allergies / Hay Fever	☐	☐	_____
Heart Failure / CHF	☐	☐	_____	Blood or Bleeding Disorders	☐	☐	_____
Depression / Anxiety	☐	☐	_____	Anemia	☐	☐	_____
Stroke	☐	☐	_____	Hepatic / Liver Disease	☐	☐	_____
Pneumonia	☐	☐	_____	Back / Spine Problems	☐	☐	_____
COPD / Emphysema / Bronchitis	☐	☐	_____	Hemorrhoids	☐	☐	_____
Asthma	☐	☐	_____	Gastrointestinal Ulcers	☐	☐	_____
Tuberculosis / TB	☐	☐	_____	Gout	☐	☐	_____
Sexually Transmitted Infection	☐	☐	_____	Heartburn / Reflux Problems	☐	☐	_____
Other Sexual Problems	☐	☐	_____	Arthritis / Joint Problems	☐	☐	_____
Abnormal Pap Smear	☐	☐	_____	Skin Disease	☐	☐	_____
Prostate Problems	☐	☐	_____	Seizures	☐	☐	_____
Cancer (please list type)	☐	☐	_____	Alcohol / Drug Problems	☐	☐	_____
Number of Pregnancies	_____			Number of Live Births	_____		

Other: _____

Is your Mother alive? ☐ Yes ☐ No If not, age at death and cause of death: _____

Is your Father alive? ☐ Yes ☐ No If not, age at death and cause of death: _____

Surgical History

Please list all OPERATIONS you have had and give the approximate DATE of each:

Operation	Date	Operation	Date
☐ Appendectomy	_____	☐ Joint Surgery	_____
☐ Cholecystectomy (gallbladder out)	_____	☐ _____	
☐ Hysterectomy	_____	☐ _____	
☐ Heart Surgery	_____	☐ _____	

PLEASE FILL OUT BOTH SIDES OF THIS FORM

Today's Date: _____

SCL Health MEDICAL GROUP

COMPREHENSIVE HEALTH ASSESSMENT

Health Maintenance

When was your LAST (Please give an approximate date):

Pap Smear _____ Prostate Exam / PSA _____ DEXA Scan _____ Cholesterol Check _____

Breast Exam _____ Stool Check for Blood _____ Mammogram _____ Colonoscopy Exam _____

Dental Exam _____ Complete Physical _____ Eye Exam _____

Social / Occupational History

Marital Status: ☐S ☐M ☐D ☐W Hobbies / Recreation: _____

Present Occupation? _____

Previous Occupation? _____

Have you ever worked with chemicals, paints, asbestos or other hazardous materials? If so, which ones? _____

Have you ever been exposed to any environmental hazards such as radiation, toxic waste or lead paint? If so, which ones? _____

Lifestyle / Safety

Do you use tobacco products?	☐ Yes ☐ No	If yes, what kind? _____ How much? _____
Do you drink alcohol?	☐ Yes ☐ No	If yes, what kind? _____ How much per week? _____
Do you drink caffeine?	☐ Yes ☐ No	If yes, what type / how much? ☐ coffee _____ ☐ tea _____ ☐ soda _____
Do you exercise?	☐ Yes ☐ No	If yes, what type / how much? ☐ cardio ☐ weights ☐ swim ☐ other _____
Do you use sunscreen?	☐ Yes ☐ No	
Do you follow a particular diet?	☐ Yes ☐ No	☐ low fat ☐ low salt ☐ low carbohydrate ☐ vegetarian ☐ vegan ☐ gluten-free
Do you have smoke detectors?	☐ Yes ☐ No	
Do you have a gun in your house?	☐ Yes ☐ No	If yes, is it under lock and key? _____
Do you wear a seatbelt?	☐ Yes ☐ No	
Have you travelled outside of the US?	☐ Yes ☐ No	If yes, where? _____

ANSWERING THE FOLLOWING QUESTIONS WILL HELP US PROVIDE THE BEST POSSIBLE CARE. YOUR ANSWERS WILL BE CONFIDENTIAL.

Do you use drugs? (cocaine, marijuana, opiates, etc…)	☐ Yes ☐ No	If yes, what type? _____
Have you been sexually active?	☐ Yes ☐ No	If yes, with ☐ men ☐ women ☐ both
Do you practice safe sex?	☐ Yes ☐ No	If yes, what method of protection do you use? _____
Do you use other contraception?	☐ Yes ☐ No	If yes, what? ☐birth control pills ☐IUD ☐sponge ☐condoms ☐diaphragm ☐rhythm method

Immunizations

Have you had any of these IMMUNIZATIONS?

Influenza / Flu	☐ Yes ☐ No	Date:_____	Hepatitis B	☐ Yes ☐ No	Date: _____
Tetanus / Td alone	☐ Yes ☐ No	Date:_____	HPV / Cervical Cancer	☐ Yes ☐ No	Date: _____
Tetanus with Pertussis / Tdap	☐ Yes ☐ No	Date: _____	Zoster / Shingles	☐ Yes ☐ No	Date: _____
Pneumonia / Pneumovax	☐ Yes ☐ No	Date: _____	Meningococcal	☐ Yes ☐ No	Date: _____

Patient Health Questionnaire (PHQ-2): Please circle your response:

Over the past 2 weeks, how often have you been bothered by any of the following problems?

		Not at All	Several Days	More Than Half the Days	Nearly Every Day
1)	Little interest or pleasure in doing things	0	1	2	3
2)	Feeling down, depressed or hopeless	0	1	2	3

X _____ Date: _____

Patient Signature *(The above is accurate to the best of my knowledge)*

X _____ Date: _____

Provider Signature *(Intake form reviewed)*

PLEASE FILL OUT BOTH SIDES OF THIS FORM