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PATIENT'S HEALTH QUESTIONNAIRE

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them back. We may ask for clarification if needed. Thank you for your help.

Today's Date: ______________________ Date of Birth: ______________________

Name: ____

What would you like to talk about today?

____

____

MEDICAL HISTORY

List any medication allergies or reactions:

____

____

Check to indicate if you have ever had any of the following:

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Asthma
- ☐ Heart Attack
- ☐ Kidney disease
- ☐ Hepatitis
- ☐ Thyroid disease
- ☐ Seizures
- ☐ Stroke
- ☐ Depression
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Eye problems
- ☐ CAD
- ☐ CHF
- ☐ Cancer-type
- ☐ Cancer type: ______________________
- ☐ STD type: ______________________
- ☐ Other, please explain ______________________

List any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery / reason for hospitalization / location *Date*

____

____

____

If you have any other medical problems or serious injuries that are not listed above, describe here:

____

____

____

When was your last physical?

____

List all medications, including vitamins, herbal or natural supplements and prescription medications which you are currently taking. Please note dosage if possible.

Medication name	*Strength*	*Dosage*	*Medication name*	*Strength*	*Dosage*

Pharmacy other than Ferris Pharmacy Care Clinic:

Are you currently receiving care from any other doctors, chiropractors, naturopaths, or other health care professionals?

Provider's name	*Condition being treated*

List your immunizations and approximate date:

Tetanus	Date	Influenza	Date
Pneumonia	Date	Hepatitis B	Date
Tdap	Date	Other	

If you have had any of the following tests, please note when the test were and what the results were:

Test	*Approximate date*	*Result*
Cholesterol		
Pap smear/pelvic		
Mammogram		
Blood in stool		
HIV		
Colonoscopy		
Hepatitis C		
C/T		
EKG or Stress test		

HEALTH HABITS

Do you exercise regularly? ☐ Yes ☐ No

If yes, method and how often?

Are you trying to practice healthy eating habits? ☐ Yes ☐ No

If yes, describe your plan

Do you often feel sad or depressed? ☐ Yes ☐ No

Do you smoke or use tobacco products? ☐ Yes ☐ No ☐ Quit

Number of cigarettes each day__________ For how many years?__________

Other forms of tobacco used __________

Have you regularly used other drugs?__________

If so, are you still using and kind?__________

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit

How much?__________ How often?__________

Do you feel in control of your drinking?__________

PERSONAL HISTORY

Married/significant other? ☐ Yes ☐ No Others living in your home? ☐ Yes ☐ No

Are you employed? ☐ Yes ☐ No If yes, type of work__________

If no, state reason: (by choice, retired, disability, other)__________

____

In the past year, have there been any major changes in your life like marriage, divorce, death of a family member or close friend, illness or injury, or change in job situation? ☐ Yes ☐ No

Do you some sort of church or spiritual support? ☐ Yes ☐ No

The following questions apply to your sexual history:

Are you sexually active? ☐ Yes ☐ No With: ☐ Men ☐ Women ☐ Both

Do you feel you are at risk for HIV/AIDS? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No

Do you use any type of birth control? ☐ Yes ☐ No Type __________

For Women Only:

Have you ever been pregnant? ☐ Yes ☐ No If yes, # of live births__________

Miscarriages or abortions?__________ Do you still have menstrual periods? ☐ Yes ☐ No

If no, when did they stop?__________ If yes, are periods regular?__________

FAMILY HISTORY

List any diseases that run in your family. Include parents, siblings and grandparents.

Relationship

☐ Alcoholism or drug abuse __________

☐ Cancer/type __________

List any diseases that run in your family. Include parents, siblings and grandparents.

	Relationship
☐ Diabetes	______________
☐ Heart disease	______________
☐ High blood pressure	______________
☐ High cholesterol	______________
☐ Osteoporosis	______________
☐ Mental Illness/dementia	______________
☐ Stroke	______________
☐ Thyroid disease	______________
☐ Other	______________

Do you have any other concerns or comments you would care to make?

____

____

____

____

Form completed by: ☐ Patient ☐ Authorized representative

____

Signature ***Print Name***

I, ______________________________ hereby affirm that I have read the Hope House Free Medical Clinic Patient Welcome Letter, and completed the Registration and Eligibility Screening and that the information given regarding employment status and household income level is correct.

I consent to receiving services at Hope House Free Medical Clinic (HHFMC), which may include assessment, routine diagnostic procedures, medications, and such medical treatment as the Health Care Provider considers to be necessary for my care.

I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantee will be made to me as to the result of examination or treatment at HHFMC. I understand that the services I receive at HHFMC are being provided by health care practitioners and other volunteers who are not receiving compensation and, as provided by Federal & State Law, are not liable for civil damages as a result of acts or omissions that may occur in providing services to me, except acts of omissions amounting to gross negligence or willful and wanton misconduct.

I understand that I am responsible for my own valuables white at HHFMC and that HHFMC is not responsible for loss or damage to any valuables/personal property.

My signature below constitutes my acknowledgment that I understand the above affirmation, consent and agreement and agree to its contents.

______________________________ ______________

Signature of Patient or Responsible Party ***Date***

______________________________ ______________

HHFMC Staff Signature ***Date***

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REGISTRATION AND ELIGIBILITY SCREENING

Today's Date: ______________________________ Date of Birth: ______________________________

Name: ____

Gender: ______________________________ Visit Status: ☐ New ☐ Returning

Address: (include city, zip code, and county):

____

Phone:

Cell ______________________________

Home ______________________________

Work ______________________________

Emergency Contact:

Name ______________________________

Phone ______________________________

Relationship ______________________________

Marital Status: ☐ Married ☐ Not Married

Spouse Name ______________________________

Ethnicity:

☐ American Indian/Alaska Native

☐ African American

☐ Native Hawaiian

☐ White

☐ Asian

☐ Hispanic/Latino

☐ Pacific Islander

☐ Other

Education Level:

☐ < High School

☐ Some College

☐ College Graduate

☐ High School Diploma

☐ Tech. School

Current Health Insurance: (check all that apply)

☐ No insurance

☐ Medicare

☐ Private Insurance

☐ Healthy Michigan Plan

☐ VA

☐ Have to spend down of $ ____________/mo.

☐ New provider, waiting for appt. with Dr. ________________ Date of appt. ________________

Income Sources:

☐ Employment

☐ Unemployment

☐ Veteran's/Military

☐ DHS cash/food

☐ SSI

☐ No income

☐ Retirement/SS

☐ Disability/Worker's Comp

☐ Support from family

Employment Status: (check all that apply)

- ☐ Not Employed
- ☐ Part Time
- ☐ Full Time

Employer(s): ______________________________

Household Income Level: ($ monthly)

- ☐ <$999
- ☐ $1,500–$1,999
- ☐ $2,500–$2,999
- ☐ $1,000–$1,499
- ☐ $2,000–$2,499
- ☐ > $3,000

I Live In:

- ☐ Own home
- ☐ Rental home
- ☐ Relatives home
- ☐ Homeless shelter
- ☐ Homeless
- ☐ Motel/other temporary housing
- ☐ Subsidized housing
- ☐ Apartment
- ☐ Other

Usual Source of Health Care:

- ☐ Emergency Room
- ☐ Family Doctor
- ☐ Urgent Care
- ☐ Gynecologist
- ☐ None
- ☐ Other

Why did you choose Hope House?

- ☐ Can't afford regular doctor
- ☐ Can't afford to keep insurance
- ☐ No regular doctor
- ☐ Lost my job/insurance
- ☐ Can't afford prescriptions
- ☐ Can't get an appointment
- ☐ Evening hours

Reason for Today's Clinic Visit:

____

____

I declare that the above information is correct and true to the best of my knowledge. I understand that this information will be verified and reviewed to determine my eligibility for services at Hope House Free Medical Clinic. I also understand it is my responsibility to inform staff of any changes in my information.

______________________________ ______________

Signature of Patient or Responsible Party ***Date***

______________________________ ______________

HHFMC Staff Signature ***Date***