Long Valley Health Center
Patient Health Questionnaire

Full Name: _____

Date of Birth: _____

Please take the time to complete this form as best you can. **Today's Date:** _____

This information is important to your provider in determining your overall care.

Have you seen any medical providers or specialists in the past 2 years? ☐ Yes ☐ No

Provider Name(s): _____

Reason: _____

Have you been hospitalized or in the emergency room in the past 2 years? ☐ Yes ☐ No

Reason: _____

PAST MEDICAL HISTORY:

Have you had any of the following health conditions? Please check all that apply.

☐ Hypertension (High blood pressure)	☐ Chronic Pain Location: _____	☐ Hepatitis
☐ High cholesterol	☐ Cancer Type:_____	☐ Liver disease
☐ Coronary artery disease	☐ Enlarged prostrate	☐ Kidney or bladder disease
☐ Atrial fibrillation	☐ Diabetes	☐ Gallbladder disease
☐ Cardiac chest pain	☐ Thyroid disease	☐ Migraine headaches
☐ Heart attack	☐ Hormone imbalance	☐ Eye or visual problems
☐ Stroke	☐ Asthma	☐ Dental problems
☐ Anemia	☐ COPD (emphysema)	☐ Alcohol or Substance Abuse Specify: _____
☐ Bleeding or clotting problems	☐ Tuberculosis	☐ Anxiety
☐ Blood transfusion	☐ Sexually transmitted disease	☐ Depression
☐ Seizures or epilepsy	☐ HIV infection or AIDS	☐ Other Mental Health Concerns Specify:_____
☐ Autoimmune disorder	☐ Stomach ulcers	☐ Memory or cognition problems
☐ Arthritis	☐ Crohn's disease (Inflammatory Bowel Disease)	☐ Other _____
☐ Carpal tunnel syndrome	☐ GERD (Reflux)	☐ Other _____

What is your primary language? _____ **In what country were you born?** _____

Have you travelled outside of the US in the last 5 years? ☐ Yes ☐ No

Where have you travelled? _____

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CURRENT MEDICATIONS:

List all medications you are currently taking including over the counter medications, herbs, supplements, or vitamins.

_____

_____

_____

ALLERGIES:

If yes, please list below and **describe reaction**.

Are you allergic to any medications? ☐ Yes ☐ No

Any other allergies such as foods, pollens, insects, adhesives, or latex? ☐ Yes ☐ No

_____

IMMUNIZATIONS:

Are your immunizations up-to-date? ☐ Yes ☐ No ☐ Unsure

Have you had a tetanus shot? ☐ Yes ☐ No ☐ Unsure Date: _____

PAST SURGICAL HISTORY:

Have you had any of the following medical procedures?
Please check all that apply and provide the year that the procedure was done.

SURGERY	YEAR	SURGERY	YEAR	SURGERY	YEAR
☐ Angioplasty		☐ Heart bypass surgery		☐ Mastectomy	
Stent? Y/N		☐ Hernia repair		☐ Pacemaker	
☐ Appendectomy		☐ Hip replacement		☐ Prostate Surgery	
☐ Back surgery		☐ Hysterectomy		☐ Thyroidectomy	
☐ Bowel surgery		*Reason:*		☐ Tonsillectomy	
☐ Breast biopsy		*Still have cervix?* Y N		☐ Tubal Ligation	
☐ Caesarean section		*Still have ovaries?* Y N		☐ Vasectomy	
☐ Carpal tunnel release		☐ Knee surgery		☐ Other	
☐ Cataract extraction		☐ LASIK surgery		☐ Other	
☐ Gallbladder surgery		☐ Liver biopsy			
☐ Gastric bypass				☐ None	

HEALTH SCREENINGS:

Have you had a pap smear? ☐ Yes ☐ No Date of most recent pap: _____

If the pap smear was not done at LVHC, please provide doctor's name: _____

Have you had a mammogram? ☐ Yes ☐ No Date of most recent mammogram: _____

Have you had a colonoscopy or other colon cancer screening? ☐ Yes ☐ No Date: _____

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FAMILY HISTORY:

Have any of your close relatives suffered from chronic or fatal illnesses? Please check all that apply. Please tell us how old they were when the illness began and if fatal, how old they were when they died.

Please check here if you were adopted: ☐

ILLNESS	FATHER	AGE	MOTHER	AGE	SIBLING	AGE	OTHER FAMILY (*please specify*)	AGE
ALIVE & WELL	☐		☐		☐		☐	
Diabetes	☐		☐		☐		☐	
High blood pressure	☐		☐		☐		☐	
High cholesterol	☐		☐		☐		☐	
Heart disease	☐		☐		☐		☐	
Stroke	☐		☐		☐		☐	
Cancer Type:	☐		☐		☐		☐	
Asthma	☐		☐		☐		☐	
Arthritis	☐		☐		☐		☐	
Osteoporosis	☐		☐		☐		☐	
Autoimmune disorder	☐		☐		☐		☐	
Obesity	☐		☐		☐		☐	
Kidney disease	☐		☐		☐		☐	
Blood disease	☐		☐		☐		☐	
Alzheimer's disease	☐		☐		☐		☐	
Depression	☐		☐		☐		☐	
Mental illness	☐		☐		☐		☐	
Alcohol or Substance Abuse	☐		☐		☐		☐	
Hearing loss	☐		☐		☐		☐	
Vision loss	☐		☐		☐		☐	
Other:	☐		☐		☐		☐	

Are You Hearing or Vision Impaired? ☐ Y ☐ N Accommodations Needed? ☐ Y ☐ N

If yes, please describe: _____

Do you have a caregiver? ☐ Yes ☐ No

Do you need help with self-care needs? ☐ Yes ☐ No

Do you need help with reading or completing forms? ☐ Yes ☐ No

Have you completed any kind of advance directive like a living will, Durable Power of Attorney for Health Care or a POLST form? ☐ Yes ☐ No

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TOBACCO, DRUG AND ALCOHOL USAGE:

Do you smoke tobacco products? ☐ Current ☐ Past ☐ No
Do you chew tobacco? ☐ Current ☐ Past ☐ No
Do you smoke marijuana? ☐ Current ☐ Past ☐ No
Do you vape? ☐ Current ☐ Past ☐ No
Are you exposed to secondhand smoke? ☐ Yes ☐ No

Do you currently use any recreational drugs? ☐ Yes ☐ No
If yes, please describe: _____

How often do you have a drink containing alcohol? _____
How often do you have a drink containing caffeine? _____

SOCIAL HEALTH:

Do you currently have housing? ☐ Yes ☐ No ☐ Temporary
How many people live in your household? _____

Do you have problems with your housing such as mold, inadequate heat or cooling? ☐ Yes ☐ No
If yes, please describe: _____
In the past year, has electric, gas, water or phone services been shut off in your home? ☐ Yes ☐ No

Do you have difficulty paying for medical care, prescriptions or insurance? ☐ Yes ☐ No
Do you have difficulty with access to transportation? ☐ Yes ☐ No
Do you have difficulty paying for or getting enough quality food? ☐ Yes ☐ No

Do you feel safe in your home? ☐ Yes ☐ No
Do you feel safe in your relationships? ☐ Yes ☐ No

Would you like to speak to someone about these or other concerns? ☐ Yes ☐ No

PATIENT UPDATE: In the last 2 years, have you had any medical, health or social changes?

If yes, please describe: _____

_____

_____

_____

Please sign and date. Thank you for completing this important form about your health.

Signature: _____ **Date:** _____