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HEALTH INVENTORY

PATIENT NAME: _____
BIRTH DATE: _____
SOCIAL SECURITY #: _____

MEDICAL INFORMATION

Who is your primary care provider? ☐ I do not have a primary care provider – **OR** –

Primary care provider or Clinic Name: _____

Address_____

Telephone #:_____ FAX #_____

About when was your most recent physical exam? _____ laboratory tests? _____

Do you see any other specialist/s and if so, what type/s?_____

_____

Please list all **CURRENT MEDICATIONS**, including doses and for how long if known (also include all current over the counter (OTC) medications, supplements, vitamins, herbal remedies, etc.):

_____
_____
_____

Please list all **PAST Medications** and doses, when taken, and for how long to the best of your memory:

_____
_____
_____

ALLERGIES: please list all **food, environmental, and medication,** allergies and reactions they cause:

_____
_____
_____

1. Have you ever had any surgeries or overnight hospital stays? ☐ **Yes** ☐ **No**
2. If yes, please list (with reason for admission and date):

_____

Have you had any significant injuries? ☐ **Yes** ☐ **No**

Explain:_____

3. Please indicate if you have any of the following problems **NOW, IN THE PAST, OR NEVER.**

(Please use an "x" to mark the appropriate answer.)	**Now**	**Past**	**Never**	**Decline to Answer**
Anemia	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Bladder or Kidney Infections	☐	☐	☐	☐
Chronic Diarrhea	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Epilepsy or Seizures	☐	☐	☐	☐
Gall Bladder Disease	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐
Kidney Disease/Stones	☐	☐	☐	☐
Liver Disease/Hepatitis	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Venereal Disease (Syphilis/Gonorrhea/Chlamydia)	☐	☐	☐	☐
Thyroid Disease/Goiter	☐	☐	☐	☐
Tumors/Cancer	☐	☐	☐	☐
Ulcers (Stomach or Intestine)	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐

4. Do you have any other significant medical conditions that are not listed above? ☐ **Yes** ☐ **No**

If yes, explain_____

_____

5. Please indicate if you have any of the following persisting conditions at this time:

(Please use an "x" to mark the appropriate answer.)	**Yes**	**No**	**Decline to Answer**
Severe or unusual headache	☐	☐	☐
Hearing Problems	☐	☐	☐
Problems with vision (other than nearsightedness or farsightedness)	☐	☐	☐

(Please use an "x" to mark the appropriate answer.)	**Yes**	**No**	**Decline to Answer**
Sinus problems or hay fever	☐	☐	☐
Hoarseness	☐	☐	☐
Difficulty or Pain on urinating or blood in urine	☐	☐	☐
Severe skin problems	☐	☐	☐
Unexplained weight loss or gain	☐	☐	☐
Chest pains or discomfort	☐	☐	☐
Shortness of breath	☐	☐	☐
Stomach problems (pain, nausea, or vomiting)	☐	☐	☐
Cough, phlegm, bloody cough	☐	☐	☐
Diarrhea or constipation or vomiting	☐	☐	☐
Blood in bowel movements or black bowel movements	☐	☐	☐
Night Sweats	☐	☐	☐
Painful joints	☐	☐	☐

FOR WOMEN ONLY

6. How old were you when you first started menstruating? _____years

- Usual length of menstrual period? _____ days
- Have you stopped having menstrual periods? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**
- How long ago did your most recent menstrual period begin? _____

7. Are you using any form of birth control?

If yes, which?_____

How long? _____

Have you ever taken birth control pills or other hormones? _____

If you stopped, why? _____

8. Are you pregnant or are you planning a pregnancy? ☐ **Yes** ☐ **No** ☐ **Maybe** ☐ **Decline to Answer**

Comments:_____

9. Do you have problems with:

A. Irregular, painful or heavy menstrual periods? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

B. Bleeding between periods or after menopause? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

C. Vaginal discharge, pain, or itching? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

D. "Hot flashes?" ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

E. Too high/ low libido? (if yes, circle one) ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

If yes, how long? _____

10. What is the date of your last Pap smear? _____

- Were there any abnormalities? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

11. Do you have problems with pain or lumps in your breast? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

12. Have you ever had a mammogram (breast x-ray)? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

13. During the week before your period starts, do you have a serious problem with your mood – like depression, anxiety, irritability, anger, or mood swings? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

14. If yes, do these problems go away by the end of your period? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

15. Are you having difficulty getting pregnant? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

16. Number of pregnancies: _____

17. Did you have any physical or emotional problems during or after pregnancy? _____

PREVENTATIVE CARE

18. Do you follow any special diet? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

19. Do you exercise regularly? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

20. In general, would you say your health is: ☐ **Excellent** ☐ **Very Good** ☐ **Good** ☐ **Fair** ☐ **Poor**

21. Do you live alone? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

22. If not, with whom do you live? _____

23. Do you have difficulty shopping or carrying home a 10-lb bag? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

24. Do you have difficulty dressing yourself? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

25. Have you had 3 or more falls during the past year? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

26. Have you ever had any contact with a person with TB? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

27. *Risk Factors for infection with HIV, the AIDS virus, include:*

-Hemophilia and/or receiving a blood transfusion between 1979-1985
-Unprotected heterosexual or homosexual sex, especially with multiple partners
-Intravenous drug use
-Sexual contact with an HIV-positive person or individuals with other factors listed above

Do you have any questions about these HIV risk factors or do you want to discuss them with your clinician?
☐ **Yes** ☐ **No** ☐ **Decline to Answer**

LANGUAGE/EDUCATION/SPIRITUALITY

28. Are you having difficulties with your memory? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

29. Do you plan to include your family/partner/significant other in your mental health care?

☐ **Yes** ☐ **No** ☐ **Decline to Answer**

30. What language are you most fluent in: ☐ English ☐ Spanish ☐ Cantonese ☐ Other_____

31. Do you have learning difficulties we should be aware of? ☐ **Yes** ☐ **No** ☐ **Decline to Answer**

If yes, please describe: _____

32. Do you engage in or identify with a particular religious or spiritual practice?

☐ **Yes** ☐ **No** ☐ **Decline to Answer**

Anxiety

33. Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way?
☐ **Yes** ☐ **No** ☐ **Decline to Answer**

34. In the past month, were you fearful of or embarrassed by being watched, being the focus of attention, or fearful of being humiliated? This includes things like speaking in public eating in public or with others, writing while someone watches, or being in social situations.
☐ **Yes** ☐ **No** ☐ **Decline to Answer**

35. In the past month, have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing?
☐ **Yes** ☐ **No** ☐ **Decline to Answer**

36. In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting, or checking things over and over, or repeating, collecting, arranging things, or other superstitious rituals?
☐ **Yes** ☐ **No** ☐ **Decline to Answer**

37. Please indicate whether you are biologically male or female.
☐ **Male** ☐ **Female** ☐ **Transgender (Discuss with your clinician)**

Outpatient Pain Screen

38. Do you have any current or recurring pain that interferes with the quality of your life?

_____Yes → If yes, please go the next question below.

_____No → If no, Pain Screen complete, please go to question #40.

Are you satisfied with your current pain control? _____Yes _____No

39. Where is your pain? _____

- When do you have your pain?_____
- When did your pain first begin? _____
- What was or is the cause of your pain? _____
- Check the boxes next to the words that best describe the quality of your pain.

Aching		Exhausting		Penetrating		Stabbing	
Burning		Gnawing		Pressure		Squeezing	
Crampy		Miserable		Radiating		Tender	
Deep		Nagging		Sharp		Throbbing	
Dull		Numb		Shooting		Unbearable	

- What is the worst amount of pain you had in the last month? (on a scale of 1 to 10, one being no pain and 10 being the worst possible pain)? _____
- Check the boxes below for any activities that have been impacted by your pain.

  ☐ cleaning ☐ driving ☐ leisure activity ☐ physical activity ☐ sex

  ☐ shopping ☐ sleep ☐ sports ☐ walking
- What medications are you taking for your pain? _____
- Are you seeing any specialists for help with your pain? _____

Substance Use History

40. How much coffee, tea soda, or other caffeinated beverage do you typically consume per day? _____

41. Have you ever used tobacco? ☐ **Yes** ☐ **No** If yes:

- How old were you when you first used tobacco? _____years old
- How much do you smoke? _____
- When is the last time you used tobacco? _____
- Number of days in the past 30 days in which you used tobacco: _____ days
- Do you mainly use: _____cigarettes _____pipes _____cigars _____other

42. Have you ever consumed alcohol (beer, wine or spirits)? ☐ **Yes** ☐ **No** If yes:

- How old were you when you first consumed alcohol? _____years old
- When is the last time you consumed alcohol? _____
- How many days in the past 30 days did you consume alcohol? _____
- Number of days in the past 30 days did you have 5 or more drinks? _____ days

  (1 drink is equal to a 12-ounce can of beer, a 4-ounce glass of wine, or a 1-ounce shot of liquor)

43. Have you ever used any Sedative/Hypnotic/anti-anxiety pills (e.g. Xanax, Valium, and Klonipin)?

☐ **Yes** ☐ **No** If yes:

- How old were you when you first used Sedatives/Hypnotics? _____years old
- When is the last time you used Sedatives/Hypnotics? _____
- Number of days in the past 30 days in which you used Sedatives/Hypnotics: _____ days

44. Have you ever used Cannabis (marijuana)? ☐ **Yes** ☐ **No** If yes:

- How old were you when you first used Cannabis? _____years old
- When is the last time you used Cannabis? _____
- Number of days in the past 30 days in which you used Cannabis: _____ days
- Do you have a medical marijuana card? ☐ **Yes** ☐ **No**

- If not, do you intend to obtain a marijuana card? ☐ **Yes** ☐ **No**

45. Have you ever used Amphetamines (speed)? ☐ **Yes** ☐ **No** If yes:

- How old were you when you first used Amphetamines? _____years old
- When is the last time you used Amphetamines? _____
- Number of days in the past 30 days in which you used Amphetamines: _____ days

46. Have you ever used Cocaine (including crack)? ☐ **Yes** ☐ **No** If yes:

- How old were you when you first used Cocaine? _____years old
- When is the last time you used Cocaine? _____
- Number of days in the past 30 days in which you used Cocaine: _____ days

47. Have you ever used Opioids (heroin, morphine, Vicodin)? ☐ **Yes** ☐ **No** If yes:

- How old were you when you first used Opioids? _____years old
- When is the last time you used Opioids? _____
- Number of days in the past 30 days in which you used Opioids: _____ days

48. Have you ever used Hallucinogens/PCP/Mushrooms? ☐ **Yes** ☐ **No** If yes:

- How old were you when you first used Hallucinogens/PCP/Mushrooms? _____years old
- When is the last time you used Hallucinogens/PCP/Mushrooms? _____
- Number of days in the past 30 days in which you used Hallucinogens/PCP/Mushrooms: _____ days

49. Have you ever used Ecstasy/MDMA? ☐ **Yes** ☐ **No** If yes:

- How old were you when you first used Ecstasy/MDMA? _____years old
- When is the last time you used Ecstasy/MDMA? _____
- Number of days in the past 30 days in which you used Ecstasy/MDMA: _____ days

50. **In the last 12 months**, about how often did you drink any kind of alcoholic beverage?

_____Everyday _____Nearly every day

_____3 or 4 times a week _____Once or twice a week

_____2 or 3 times a month _____About once a month

_____6-11 times a year _____1-5 times a year

_____Not during the last 12 months _____Decline to Answer

Family Health History

Please indicate if any immediate family member has had any of the following problems:

(Please use an "x" to mark the appropriate answer.)	Yes	Mother	Father	Sibling
Anemia	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Bladder or Kidney Problems	☐	☐	☐	☐
Gastrointestinal Problems	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Epilepsy or Seizures	☐	☐	☐	☐
Gall Bladder Disease	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Kidney Disease/Stones	☐	☐	☐	☐
Liver Disease/Hepatitis	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid Disease/Goiter	☐	☐	☐	☐
Tumors/Cancer	☐	☐	☐	☐
Ulcers (Stomach or Intestine)	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐

By my signature below, I certify that I have completed this form to the best of my ability.

PATIENT SIGNATURE: X_____ DATE:_____

If this form was completed by someone other than the patient, please complete the following:

Name (print): _____Signature_____ Date:_____

Relationship to patient: _____