

Health History Questionnaire

The Care Group, P.C.

830 Potomac Cir Suite 150

Aurora, CO 80011

303-343-3121 FAX: 303-343-3514

www.thecaregrouppc.com

Today's Date _____

The purpose of this CONFIDENTIAL questionnaire is to facilitate gathering the necessary information relative to your health. In this way, you will derive maximum benefit for the time spent, and, hopefully, we will more readily cover all important areas. If you are unsure how to answer a question, simply circle the question and we will address it with you. Thank you for your cooperation.

Name _____ Age _____

Marital Status _____ Occupation _____

Please list the medical problems for which you came to see the doctor:

Problem

Date Began

Problem	Date Began

Are you a cigarette smoker? YES NO

If YES, how many packs per day: _____ At what age did you start smoking? _____

If you are a former smoker, when did you quit? _____

Do you drink alcoholic beverages? YES NO

If YES, how many drinks per week (average): _____

Have you ever felt guilty about the amount you drink or have ever felt a need to control your drinking? YES NO

How much caffeine do you consume per day? Cups of coffee: _____ Tea, Cola, other: _____

Please list all current medications, prescription and non-prescription drugs taken regularly. Please include dosage and frequency. (If you already have a list please bring it to the front desk and we will make a copy - you do not need to rewrite everything):

Please list all drug allergies and sensitivities (e.g. penicillin - rash; ibuprofen - upset stomach):

Have you travelled out of the country within the last two years? YES NO

If YES, please list countries visited: _____

Please write in the dates for shots you have had:

Tetanus _____ Pneumococcus _____ Hepatitis _____ Influenza _____

Please list history of medical problems in your family. If deceased, list the age and cause of death if known. (i.e. father - high blood pressure - deceased age 50 - heart attack)

Please rate your overall health: POOR FAIR GOOD EXCELLENT

Do you exercise regularly? YES NO

If YES, describe the types of exercise and frequency:

How many meals do you eat each day? _____ Do you usually eat breakfast? YES NO

Do you diet frequently and/or are you dieting now? YES NO

Do you eat a balanced diet ALMOST ALWAYS SOMETIMES RARELY

Please list any food supplements or vitamins you take regularly:

FEMALE PATIENTS ONLY:

What age did menstrual cycle begin? _____ Date of last period: _____

Describe any menstrual irregularities:

Total number of pregnancies: _____ Total number of miscarriages or abortions: _____

Have you gone through the change (menopause)? YES NO

if YES, at what age? _____ Did you take calcium supplements? YES NO

Do you have or have you ever been treated for any of the following? Please circle yes or no. If you circle yes, please give date of treatment or occurrence.

Asthma or Wheezing	NO	YES	DATE: _____
Insomnia	NO	YES	DATE: _____
Hay fever or Allergies	NO	YES	DATE: _____
Snoring	NO	YES	DATE: _____
Tuberculosis	NO	YES	DATE: _____
Serious Bodily Injury	NO	YES	DATE: _____
Chronic/Persistent Cough	NO	YES	DATE: _____
Rheumatism/Arthritis	NO	YES	DATE: _____
Chronic Chest Condition	NO	YES	DATE: _____
Rheumatic Fever	NO	YES	DATE: _____
Frequent colds, sinus, or nose trouble	NO	YES	DATE: _____
Swollen or painful joints	NO	YES	DATE: _____
Stomach/duodenal ulcers	NO	YES	DATE: _____
Backache/back injury	NO	YES	DATE: _____
Persistent or recurrent indigestion	NO	YES	DATE: _____
Rupture or Hernia	NO	YES	DATE: _____
Bowel/Intestinal trouble	NO	YES	DATE: _____
Skin disease, rash, or acne	NO	YES	DATE: _____
Gall Bladder Stones or Colic	NO	YES	DATE: _____
Liver trouble or jaundice	NO	YES	DATE: _____
Dysentery or colitis	NO	YES	DATE: _____
Rectal trouble or bleeding	NO	YES	DATE: _____
Diabetes or sugar in urine	NO	YES	DATE: _____
Kidney trouble or Bright's disease	NO	YES	DATE: _____
High blood pressure or hypertension	NO	YES	DATE: _____
Heart trouble, murmurs, or heart attack	NO	YES	DATE: _____
Chest pain	NO	YES	DATE: _____
Shortness of breath	NO	YES	DATE: _____
Chronic or recurrent eye trouble	NO	YES	DATE: _____
Chronic or recurrent ear trouble	NO	YES	DATE: _____
Any birth abnormalities	NO	YES	DATE: _____
Fatigue	NO	YES	DATE: _____
Fainting spells	NO	YES	DATE: _____

Apoplexy or stroke	NO	YES	DATE: _____
Paralysis	NO	YES	DATE: _____
Epilepsy, seizures, convulsions	NO	YES	DATE: _____
Varicose veins	NO	YES	DATE: _____
Piles or hemorrhoids	NO	YES	DATE: _____
Hypoglycemia	NO	YES	DATE: _____
Painful or difficult urination	NO	YES	DATE: _____
Goiter or thyroid trouble	NO	YES	DATE: _____
High metabolism	NO	YES	DATE: _____
Low metabolism	NO	YES	DATE: _____
Cancer	NO	YES	DATE: _____
Anemia	NO	YES	DATE: _____
Albumin, blood or pus in urine	NO	YES	DATE: _____
Frequent headaches	NO	YES	DATE: _____
Migraine headaches	NO	YES	DATE: _____
Alcohol Addiction	NO	YES	DATE: _____
Drug Addiction	NO	YES	DATE: _____
Sexual problems	NO	YES	DATE: _____

Hospital admissions for: Surgery, Injury, or Maternity

Diagnosis	Month/Year	Hospital/City	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

THE CARE GROUP, P.C.

Dr. Gerard Guillory, M.D.

I understand and agree that if my insurance does not cover any or all of my medical expenses that I will be responsible for paying the total amount due. I also understand that if I do not have insurance at this time, I am responsible for all medical costs at the time of service and plan on paying all monies due at the end of my visit today.

Signature

Date

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Name _____ Date _____

In order to better serve you, please read and initial the following information:

Most insurance carriers consider a complete physical exam a preventative medicine service. You must verify that your insurance covers this type of service, as well as the frequency of service (i.e. complete physical exam every 12 months). We understand that some carriers might not cover preventive medicine services, so it is important that you know what your benefits are. After a claim is submitted, we will not be able to change a diagnosis so that your insurance carrier will pay your claim. You will be financially responsible for any services denied by your carrier.

Initials: _____

It is your responsibility to know your insurance benefits. If your insurance requires that you have a referral to specialists you are responsible for making sure your referral is at the specialist office before your visit. You also need to make sure that the specialist participates with your insurance group.

Initials: _____

It is your responsibility to make sure that the insurance information we have in your chart is correct. You are also responsible to keep us updated with current phone number and addresses. We need all of this information to be updated at all times.

Initials: _____

Please give us your e-mail address so that we may better serve you with timely news and notifications from the office. If you have given us your e-mail address previously and have not received confirmation with a link to the web site then we may not have your correct e-mail address.

E-mail address: _____

Medicare Patients: This office accepts Medicare assignment. Medicare pays 80% of the amount they approve after you meet your deductible. You are responsible for your deductible and the remaining 20%. If you have insurance that covers the remaining 20%, please provide us with that information.

Initial if you are a Medicare patient: _____

Information in your chart will only be shared with other medical facilities/providers and insurance companies. Please ask us for a form if you would like information to be shared with specific people other than health care providers.

I hereby acknowledge that I received The Care Group, P.C.'s Notice of Privacy Practices and have read all of the above information.

Signature _____ DOB _____