Pillar
MEDICAL ASSOCIATES, PC
COMPASSION • UNDERSTANDING • EXPERTISE
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Health History Questionnaire

Patient Name& Address

Name: _____ Date of Birth: _____
Address: _____ City: _____ State/Zip:_____
Phone Number: _____ Social Security Number: _____
Email:_____
Marital Status:

☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never married
Spouse's Name: _____ Spouse's Contact Number:_____

Race:

☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan
☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ I decline to Specify

Ethnicity:

☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ I decline to specify

Primary Language other than English: ☐ Yes ☐ No If No, which language is primary:_____

Insurance Information

Insurance Name	Subscriber	Relationship to subscriber	Member ID	Copay

Pharmacy Information

Pharmacy Currently Using: _____
Address: _____

Phone & fax: _____

Responsible Party (Send Bills to)

Name: _____ Home/Cell number: _____Work:_____
Address: _____ City: _____ State/Zip:_____

Please Indicate if Power of Attorney ☐ Yes ☐ No

Please Indicate if Responsible Party will access Patient Portal: ☐ Yes ☐ No If yes, Date of Birth_____

Contact in Case of Emergency

Name	**Relationship**	**Address, City, State, Zip**	**Home/Cell Phone**	**Primary or Secondary Contact**

Social History
Place of Birth: _____
Highest education level: _____
Occupation prior to retirement: _____
Place of residence prior to current: _____
Religious Preference: _____

Family History
Mother age of death _____
Mother cause of death _____
Father age of death _____
Father cause of death _____

Children:

☐ Yes ☐ No

Name of Child	Age of Child	Address	**If deceased**, Age at death	**If deceased**, Cause of death

Health Habits

Smoking history

☐ Non-Smoker

☐ Ex-smoker Year Quit _____
Number of Packs Smoked Per Day _____

☐ Smoker Number of Packs Smoked Per Day _____
Number of years smoking _____

Alcohol consumption history

☐ Never consumed

☐ Yes, I consume Amount of alcohol consumed per week _____

Immunization history

Do you receive a flu shot every year? ☐ Yes ☐ No

Have you ever had Tuberculosis? ☐ Yes ☐ No

Have you ever been around anyone with TB? ☐ Yes ☐ No

Current Health

Describe general health compared to others the same age: ☐ Excellent ☐Good ☐ Fair ☐ Poor

Have you fallen within the past year: ☐ Yes ☐ No

Have you recently (within the last year) lost interest or pleasure in doing activities: ☐Yes ☐ No

Have you recently (within the last year) felt down, depressed and/or hopeless: ☐ Yes ☐ No

General health over the past 5 years: _____
_____

Weight: changes in past 6 month's _____ past year_____

Describe typical day/hobbies: _____

Health Maintenance

Do you want to continue with yearly mammograms ☐ Yes ☐ No

Do you want to continue with yearly colon cancer screening: ☐ Yes ☐ No

Activities of Daily Living

Are you able to?
(I = independently, A = with assistance, D = dependent on others for help)

Get dressed	☐I ☐A ☐D	Eat	☐I ☐A ☐D
Drive	☐I ☐A ☐D	Prepare Meals	☐I ☐A ☐D
Baths	☐I ☐A ☐D	Manage Money	☐I ☐A ☐D
Use Phone	☐I ☐A ☐D	Walk	☐I ☐A ☐D
Use toilet	☐I ☐A ☐D	Telephone	☐I ☐A ☐D
Getting up from Chair	☐I ☐A ☐D	Shop	☐I ☐A ☐D

Do you use? ☐ Walker ☐Cane ☐Commode ☐Raised toilet seat ☐ Hospital bed ☐ Wheelchair
Other assistive devices:

Past Medical History – Please check all the apply

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Emphysema
- ☐ Depression
- ☐ Anxiety
- ☐ Gout
- ☐ Osteoporosis
- ☐ Stomach Ulcers
- ☐ Kidney Stones
- ☐ Stroke
- ☐ Seizures
- ☐ Blood Clot in Legs or Lung
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Cancer
- ☐ Kidney Failure
- ☐ Recurrent Bladder Infections
- ☐ History of Psychiatric Care of Hospitalization
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis

Surgery
Please list all surgeries and date of surgery

Type of Surgery	Date

Hospitalizations

Please list any hospitalizations over the past 5 years

Date of Hospitalization	Reason

Medications: PLEASE BRING ALL PILL BOTTLES TO YOUR FIRST APPOINTMENT.

Name of Medicine	Strength of Pill	Number of Pills	Number of Times per Day
Example: Norvasc	*5 mg*	*2 tablets*	*2 times a day*

Allergies

List ALL allergies to medications and food along with reaction:

Allergic to:	Reaction

Advanced Directive

Do you have a Health Care Proxy? ☐ No ☐ Yes

Do you have a Living Will? ☐ No ☐ Yes

Do you have a MOLST? ☐ No ☐ Yes

Please provide copies of the above documents if available

Person completing this form

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____