RESIDENTIAL MEDICAL KARE

Health History Questionnaire

Your answers on this form will help your healthcare provider better understand your medical concerns and conditions. All questions on this form will be kept strictly confidential.

Allergies

Please list your allergies (medications, food, bee stings, etc.) and the reactions you experienced.

Allergy	Reaction
1.	
2.	
3.	

Preferred Pharmacy:_____

Pharmacy Phone Number: _____

Medications: Please list all the medications you are taking. This includes prescribed drugs and over-the-counter drugs (including vitamins, and supplements).

Medication Name	Strength	Frequency Taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		

Health Care Team - Please list any other specialist(s) you see for other health conditions (i.e. cardiologist, eye specialist, pulmonologist, podiatrist). Please include their addresses and phone numbers.

Specialist	Name and Contact Information
1.	
2.	
3.	
4.	
5.	

Immunization History

Vaccine	Date	Vaccine	Date
Flu Shot		Shingles	
RSV Shot		Covid-19 (Most Recent)	
Pneumonia (Pneumovax 23)		RSV	
Pneumonia(Prevnar)		Tetanus	

Past Medical History (check all that apply)

☐ Addiction	☐ Eye Disorder	☐Neurologic Problems
☐ Anemia	☐ Glaucoma	☐ Osteopenia / Osteoporosis
☐ Arthritis _____	☐Gout	☐ Overactive Bladder
☐ Asthma	☐ Headaches	☒ Parkinson's
☐ Bleeding/Clotting Problem/ Anticoagulants	☐ Hearing Aids / Problems	☐ Prostate Disease
☐ Bowel Problem	☐ Heart Disease	☐ Seizure Disorder
☐ Cancer:_____	☐ Heart Failure	☐ Skin Conditions
☐ Carotid Artery Disease	☐ Heart Valve / Murmur	☐ Stomach Problems
☐ Cataracts	☐High Blood Pressure (HTN)	☐ Stroke
☐ Chronic Pain _____	☐ Joint Replacements	Thyroid Problems ☐ Hypo ☐ Hyper
☐ Coronary Artery Disease	☐Kidney/Bladder Problems	☐ Tuberculosis
☐ Dementia: _____	☐ Liver Disease/Hepatitis	Other:
☐Depression / Anxiety	☐Lung Disease / COPD	
☐Diabetes	☐ Macular Degeneration	
☐Elevated Cholesterol	☐Mental Health	

Past Surgical History

Surgery	Reason	Year
1.		
2.		
3.		

Preventative/Wellness

Screening	Year(s)/Location(s)	Result(s)
Colon Cancer Screening ☐ Cologuard ☐Colonoscopy		
Osteoporosis Screening (DEXA Bone Scan)		
Breast Cancer Screening (Mammograms)		
Cervical Cancer Screening (PAP Smears)		

Family Health History

			Significant Health Problems in my Family									
Relation	Age	Alive? Y/N	Alcoholism	Arthritis	Cancer	Dementia	Depression	Diabetes	Heart Disease	Hypertension	Osteoporosis	Stroke
Grandmother (Maternal)												
Grandfather (Maternal)												
Grandmother (Paternal)												
Grandfather (Paternal)												
Father												
Mother												
Brother/Sister												
Brother/Sister												
Other:												

Social History

Education	Marital Status	Sexual	Living Situation
☐ 8th grade or less ☐ High School ☐2 Yr College ☐4 yr College ☐Post Graduate **Occupation:**	☐Married ☐Separated ☐Divorced ☐Widowed ☐Domestic Partner ☐Single	Are you sexually active? ☐ Y ☐N What is your sexual orientation? ☐ Heterosexual ☐ Homosexual ☐ Bisexual	I live in a: ☐House ☐ Apartment/Condo ☐ Independent Living ☐ Assisted Living ☐ Memory Care Do you live with anyone? Who?
Exercise	**Caffeine**	**Alcohol**	**Tobacco**
☐None ☐Occasional ☐Moderate ☐Heavy	☐None ☐ Occasional ☐Moderate ☐Heavy # cups/cans per day?	Do you drink alcohol? ☐ Y ☐N How often? ☐ Occasionally ☐ Less than 3 times/week ☐ More than 3 times/week	Do you currently use tobacco? ☐ Y ☐N Cigarettes ___ pks/day Chew ____/day Cigars ____/day If not now, did you ever use tobacco? # Years Used _____ Quit date: _____

Daily Living Function

Can you perform the following functions without help? (Please check the option that applies to you)

Function	Yes, with ease	Yes, with difficulty	No, with some help	No, someone does this for me
Toilet	☐	☐	☐	☐
Feeding	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Grooming	☐	☐	☐	☐
Ambulation	☐	☐	☐	☐

Function	Yes, with ease	Yes, with difficulty	No, with some help	No, someone does this for me
Bathing	☐	☐	☐	☐
Using the telephone	☐	☐	☐	☐
Shopping	☐	☐	☐	☐
Cooking	☐	☐	☐	☐
Housekeeping	☐	☐	☐	☐
Laundry	☐	☐	☐	☐
Driving	☐	☐	☐	☐
Managing Medications	☐	☐	☐	☐
Handling Finances	☐	☐	☐	☐

Advanced care directives set up (i.e. Power of Attorney, Living Will)?

☐No ☐Yes

Power of attorney(s) (POA), if available:

Medical Care POA:_____

Financial POA: _____

Is there anything else you would like your health care provider to know?

_____

_____

_____

_____

_____

_____