GOOD SAMARITAN
HEALTH CLINIC OF PASCO, INC.

PATIENT QUESTIONNAIRE – BOTH PAGES ARE DOUBLE-SIDED!

PATIENT NAME: _____ DOB: _____ Date: _____

PLEASE FILL OUT *ALL* SECTIONS TO THE BEST OF YOUR ABILITY

**WRITE N/A IN ANY AREAS THAT DO NOT APPLY TO YOU **

WHAT BRINGS YOU TO GOOD SAMARITAN (TOP THREE ISSUES)?

1. _____
2. _____
3. _____

ALLERGIES

TYPE	Name of allergy cause	What happens?	How bad is it? (mild, moderate, severe)
DRUG			
DRUG			
FOOD			
FOOD			
ENVIRONMENTAL			

Use additional sheet if necessary.

CURRENT MEDICAL PROBLEMS

CURRENT MEDICATIONS

(***Bring medication bottles to visit for verification***)

Medication Name	Dosage	How many times a day?

FAMILY HEALTH HISTORY

FAMILY MEMBER	Health Conditions	Alive/Deceased (Age at death if deceased)
Mother		
Father		
Brother(s)		
Sister(s)		

SOCIAL HISTORY

HIGHEST LEVEL OF EDUCATION: _____ **CURRENTLY EMPLOYED?** _____

If employed, what do you do for a living? _____

If unemployed, when were you last employed and why are you not working?

_____

Do you have transportation difficulties (can't/don't drive, don't own a vehicle, etc.)? _____

If yes, how do you get here? _____

SMOKING STATUS: (Circle one) Never smoked Former smoker Current smoker

Current smokers: Are you willing to attend the Clinic's free Smoking Cessation Class? _____

How old were you when you started smoking? _____

How much do you smoke and how often (a pack a day, etc.)? _____

If you are a former smoker, how old were you when you quit? _____

Type: (circle all that apply) Cigarettes Cigars Pipes Dip Vape Other

ALCOHOL INTAKE: (Circle one) Never Occasional Moderate Heavy

How much do you drink and how often (2 drinks per day, etc.)? _____

Started Drinking Alcohol (Age) _____ Quit Drinking Alcohol: (Age) _____

Type: (circle all that apply) Beer Wine Liquor

SUBSTANCE ABUSE: (Circle one) Never used Former user Current user

If current or former user, what substance(s)? _____

How old were you when you started using? _____

How much do you/did you use? _____

CURRENT LIVING SITUATION: (Circle one)

Live alone Live with partner/children Live with parents Live with roommate Homeless

MARITAL STATUS: (Circle one) Single Married Divorced Separated Widowed

GENDER IDENTITY: (Circle one) Male Female Transgender Other

SEXUAL ORIENTATION: (Circle one) Heterosexual Homosexual Bisexual Undefined

Do you have tattoos? (Circle one) Yes No

If yes, were they done at a licensed facility? (Circle one) Yes No

Have you been screened for Hepatitis C? (Circle one) Yes No

PAST MEDICAL/SURGICAL HISTORY

Major Events/Surgeries/Accidents:

Date	Describe

IMPLANTABLE DEVICES: (Circle One) YES NO

If yes, type? _____

MEDICAL HISTORY

Check each box that applies: Have you had in the past or currently have issues with:

	Currently	Past		Currently	Past		Currently	Past
Abuse/domestic violence	____	____	Acid reflux/GERD	____	____	Anemia	____	____
Anxiety/depression	____	____	Arthritis	____	____	Asthma/COPD	____	____
Bladder/kidney problems	____	____	Blood clots	____	____	Cancer	____	____
Congestive heart failure	____	____	Diabetes	____	____	Epilepsy/seizures	____	____
Head injuries	____	____	Headache/migraine	____	____	Hearing loss	____	____
Heart disease	____	____	High blood pressure	____	____	High cholesterol	____	____
Hyperthyroidism	____	____	Hypothyroidism	____	____	Neurologic issues	____	____
Osteoporosis	____	____	Peripheral vascular	____	____	Stroke	____	____
Tooth problems	____	____	disease			Vertigo	____	____
Vision/eye problems	____	____						

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