

PATIENT QUESTIONNAIRE – BOTH PAGES ARE DOUBLE-SIDED!

PATIENT NAME:	DOB:	Date:	
PLEASE FILL C	OUT ALL SECTIONS TO	THE BEST OF YOUR A	ABILITY
**WRITE N/A	A IN ANY AREAS THAT	T DO NOT APPLY TO Y	OU **
WHAT BRINGS YOU TO C	SOOD SAMARITAN (TOP TH	REE ISSUES)?	
3.			
	ALLERGIE	<u>S</u>	
ТҮРЕ	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 PRO	<u>BLEMS</u>	

CURRENT MEDICATIONS

(<u>Bring medication bottles to visit for verification</u>)

Medication Name	Dosage	How many times a day?

FAMILY HEALTH HISTORY

FAMILY MEMBER	Health Conditions	Alive/Deceased
		(Age at death if deceased)
Mother		
Father		
D t.l / . \		
Brother(s)		
Sister(s)		
3.3.2.1(3)		

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	e 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?	

SINIORING STATUS: (Circle one) Never smoked Forme	er 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 qu	it?
Type: (circle all that apply) Cigarettes Cigars Pip	pes Dip Vape Other
ALCOHOL INTAKE: (Circle one) Never Occasiona	l Moderate Heavy
How much do you drink and how often (2 drinks per day, et	c.)?
Started Drinking Alcohol (Age) Quit Drinking Al	cohol: (Age)
Type: (circle all that apply) Beer Wine Lic	γuor
SUBSTANCE ABUSE: (Circle one) Never used Forme	er 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 Homo	sexual Bisexual Undefined
<u>Do you have tattoos? (</u> 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:

Patient Name:

MEDICAL HISTORY k each box that applies: Have you had in the past or currently have issues w			scribe	Des				Date
MEDICAL HISTORY K each box that applies: Have you had in the past or currently have issues w Currently Past Currently Past Current 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								
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DOB:

Revision: 1/31/24

Date: