Damascus
Family Medicine, Inc
388 Damascus Road. Marysville. Ohio. 43040

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F ☐ Gender Identity:	
DOB:	**Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:		**Date of last physical exam:**	
☐ **Right hand dominant** ☐ **Left hand dominant**		**Occupation:**	

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates:	☐ Shingles	☐ Chickenpox
	☐ Hepatitis A	☐ Pneumonia
	☐ Hepatitis B	☐ Prevnar 13
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*
	☐ Tetanus	☐ Tetanus/Whooping cough

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn over page

MEDICAL CONDITIONS

Check if you have, or ever have been treated for the following conditions and briefly explain.

Asthma	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No
Blood pressure	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Ear/sinus	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Gastro-intestinal problems	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Learning disorders	☐ Yes	☐ No
Menstrual problems	☐ Yes	☐ No
Musculo-skeletal	☐ Yes	☐ No
Psychological/psychiatric	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Sickle cell disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Serious injury:		☐ No
Other conditions not listed:		

List any specialists you have seen and the medical conditions they have diagnosed

Specialist Name	Condition	Date

OTHER PROBLEMS

Check if you have any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins, supplements and inhalers		
Name the Drug	Strength	Frequency Taken*
		daily 2x a day 3x a day 4x a day bedtime as needed
		daily 2x a day 3x a day 4x a day bedtime as needed
		daily 2x a day 3x a day 4x a day bedtime as needed
		daily 2x a day 3x a day 4x a day bedtime as needed
		daily 2x a day 3x a day 4x a day bedtime as needed
		daily 2x a day 3x a day 4x a day bedtime as needed
		daily 2x a day 3x a day 4x a day bedtime as needed
		daily 2x a day 3x a day 4x a day bedtime as needed
		daily 2x a day 3x a day 4x a day bedtime as needed
		daily 2x a day 3x a day 4x a day bedtime as needed

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No

Please turn over page

Tobacco	Do you use, or have you used tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
	Do you currently use marijuana?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	Are you active with:	☐ Men	☐ Women	☐ Both	
	Any discomfort with intercourse?			☐ Yes	☐ No
	If so, list contraceptive or barrier method used:		or	☐ Trying to get pregnant	
	Have you ever been forced to engage in sexual activities/intercourse?			☐ Yes	☐ No
	If so, would you like to discuss this issue with your provider?			☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of HIV?			☐ Yes	☐ No
	Have you been tested for HIV?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
	Physical and/or mental abuses have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical abuse. Would you like to discuss this issue with your provider?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Do you have little interest or pleasure doing things?	☐ Yes	☐ No
Do you feel down, depressed or hopeless?	☐ Yes	☐ No
Is stress a major problem for you?	☐ Yes	☐ No

Please turn to next page

Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Are you trying to get pregnant?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam:		
Date of last mammogram:		
Date of last colonoscopy:		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No
Date of last colonoscopy:		

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT: Please Print Name _____

Date of Birth _____ Social Security # _____

AUTHORIZATION:

From: _____

_____

_____

To: Damascus Family Medicine, Inc.
388 Damascus Road
Marysville, Ohio 43040

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. This authorization will expire 1 year from the date signed.

RECORDS REQUESTED:

_____ COMPLETE CHART
_____ SHOT RECORD
_____ RADIOLOGICAL REPORTS
_____ LABS
_____ HISTORY OR PHYSICAL
_____ OTHER _____

** For records that have more than 25 pages, please mail to 388 Damascus Road, Marysville, OH 43040**

REASON FOR TRANSFER:

_____

I understand that this medical release is to include my requested information being release to the above stated person or entity. This could include information relating to sexually transmitted disease, acquired immunodeficiency virus (HIV), mental/behavioral health services or treatment for drug/alcohol abuse. I understand that signing this authorization is authorizing the release of this information unless specified otherwise.

X _____ _____

Signature — Date
Signature of Parent/Guardian if minor child — Relationship to Patient
Signature of Legal Representative

Damascus
Family Medicine, Inc

HIPAA
Personal Information

Name: _____
Last Name First Name Middle Initial

Date of Birth: _____ **Social Security Number**: _____ **Gender**: □ M □ F □ Transgender

If Transgender: □M to F □ F to M

Marital Status: □Married □Single □Divorced □Life Partner □Separated □Widowed □Other

Ethnicity: □Hispanic □Non-Hispanic □Other: _____ **Primary Language**: _____

Occupation: _____

Home Address: _____
Street City State Zip Code

May we leave results on your answering machine or voicemail? (circle one) yes no

Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____

I understand to disclose my protected health information, Damascus Family Medicine, INC. must have my consent. I understand as a part of my treatment, payment, or health care operations, it may be necessary to disclose my PHI to another entity. Therefore, I consent to such disclosure for these permitted uses, including disclosures via fax.

I wish to add the name(s) of the following person(s) to obtain the above-mentioned information:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Is the above name person your emergency contact? □ Yes □ No

If so, Phone Number: _____

If not, in case of emergency, please contact: _____

Relationship: _____ ***Phone Number:*** _____

Do you have a Legal Guardian? □ Yes □ No

Do you have a Power of Attorney for Healthcare? □ Yes □ N

Do you have any other Advance Directives (i.e. Living Will, DNR, etc.)? □ Yes □ No

Damascus
Family Medicine, Inc

Acknowledgement of receipt of privacy notice

I have been presented with a copy of Damascus Family Medicine's Health Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand that as a part of my health care, Damascus Family Medicine, Inc. and its physicians originate and maintain records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand Damascus Family Medicine, Inc. and its physicians are not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action.

I further understand that Damascus Family Medicine, Inc. and its physicians reserve the right to change their notice and practices and prior to implementation, in accordance with section 164.520 of the Code of Federal Regulations, they will send a copy of any revised notice to the address I have provided, by US mail or email.

We participate in an organized healthcare arrangement through OhioHealth Group, LTD. (Health^4). Health^4 consists of an organized system of healthcare in which multiple covered entities participate. Through Health^4, we participate in joint activities that include utilization review, quality assessment and improvement activities, and certain payment activities. We may disclose your PHI to other participants in this organized healthcare arrangement in order to facilitate the healthcare operations activities of Health^4.

I understand that when information is disclosed in agreement with this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I fully understand and accept the terms of this consent.

Patient/Representative Signature:_____

Date:_____

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Family Medicine, Inc

Name/DOB: _____

DAMASCUS FAMILY MEDICINE PATIENT PORTAL

The Patient Portal is a means by which you can communicate with your physician's office and see certain aspects of your electronic health record through a secure Internet connection. You can send a question to your doctor; request medication refills or an appointment; review your medical summary; view lab, x-ray, and other diagnostic imaging results, and print them out at home. This is done by signing into the Patient Portal, which communicates directly with our office. The Patient Portal is our way of helping you keep track of your overall healthcare.

The portal is monitored during regular business hours. For emergencies, the best way to reach a provider after hours and on weekends is through our answering service at 888-448-2948.

We hope that you find the Patient Portal to be easily accessible and multi-functional when it comes to your personal health record.

By providing my email address in the space below, I authorize Damascus Family Medicine, Inc. to send by private health information and other electronic communication through our patient portal:

Email address: _____

How To Use the Patient Portal

Once you have signed your consent form, we will register you for your individual account; you will be provided with a user name and a password to access your patient portal. To log in – simply go to our website (www.dfmi.us) and click on the Patient Portal button on the top right-hand corner. Once you have logged in, feel free to browse around the portal and familiarize yourself with your personal health record. Should you encounter any errors, please contact us so that we can update your records.

Another option for the patient portal is to download the app on your mobile device. The app is called **Healow** by eClinicalWorks. This app allows you to access your records anywhere you have mobile access capabilities.

This service allows us to facilitate secure communication between the provider and the patient. We have made this decision because we believe that physicians and patients should be partners in health.

Feel free to contact our office should you have difficulty with the patient portal. Thank you for being involved in your health care.