KAISER PERMANENTE®

Health Care Maintenance Update

Please fill out this questionnaire so we can learn more about you and provide you with the very best medical care.

Name:

Medical Record #:

Today's date: _____ Age: _____

Occupation:_____

Hobbies/Achievements: _____

Marital Status: _____ Spouse's/Partner's Occupation: _____

If you have children, please list their ages: _____

Personal Health History

What would you like to make sure you talk about during your visit today?

_____

_____

_____

Do you have any major medical problems/conditions? ☐Yes ☐No

If yes, please list them: _____

_____

_____

Do you take any medications daily? ☐Yes ☐No

If yes, please list them below. Provide dosage information when possible.

_____

_____

Please provide a list of any OTC (over the counter) medications, vitamins and herbs that you currently take:

_____

_____

Please list any significant past medical history, hospitalizations and/or surgeries.

_____

_____

Allergies

Have you ever had an adverse reaction (allergy) to medications? ☐Yes ☐No

If yes, please list the medications and briefly describe the reaction(s).

_____

_____

Please Turn Form Over

Family Health History

(Please check the conditions that are in your family)

	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other:
Healthy							
Heart Disease							
Diabetes							
High Blood Pressure							
High Cholesterol							
Stroke							
Colon Cancer							
Breast Cancer							
Prostate Cancer							
Osteoporosis							
Other:							

Prevention: Health Behaviors

Do you use tobacco (cigarettes, pipe, chewing tobacco)? ☐Yes ☐No

In the past 3 months, have you had more than 2 alcoholic drinks at one time? ☐Yes ☐No
(1 drink = 1 ½ oz. hard liquor, 12 oz. beer, or 5 oz. glass of wine)

In the past 3 months, have you used marijuana, Ecstasy, meth, prescription medication, or any other drugs to get high? ☐Yes ☐No

Over the past 2 weeks, have you been feeling down, depressed or hopeless? ☐Yes ☐No

Over the past 2 weeks, have you had little interest or pleasure in doing things that you previously enjoyed? ☐Yes ☐No

Do you have symptoms of anxiety? ☐Yes ☐No

Do you have a lot of stress in your life? ☐Yes ☐No

If you are sexually active, do you have sex with men, women or both? ☐ Men ☐ Women ☐ Both

If you are sexually active, do you ever have sex without a condom or other form of protection against pregnancy or sexually transmitted diseases (STDs)/HIV? ☐Yes ☐No

Do you have concerns about your partner hitting, yelling, or putting you down? ☐Yes ☐No

**If you are being abused, please know that I can help you and provide you with resources and support*

Do you have healthy eating habits (balanced nutritious meals, low fat, limited fast food, etc)? ☐Yes ☐No

Are you at a healthy weight? ☐Yes ☐No

Are you physically active? ☐Yes ☐No

If yes, please briefly describe your physical activity level on a daily/weekly basis:

_____

_____

Do you take a Calcium supplement? ☐Yes ☐No

Do you take a Vitamin D supplement? ☐Yes ☐No

Do you wear a seatbelt? ☐Yes ☐No

Do you wear a helmet (if you ride a bicycle or motorcycle)? ☐Yes ☐No

Do you use sunscreen to protect your skin from the sun? ☐Yes ☐No

If you are over age 50, have you been screened for colorectal cancer with a colonoscopy, sigmoidoscopy, or stool kit (FIT, FOBT)? If yes, approximately when? _____ ☐Yes ☐No

Thank you for completing this form. Please let me know if you would like to discuss any of these items in more detail.