DESERT OASIS HEALTHCARE
PATIENT HEALTH QUESTIONNAIRE

(Please Print)

Today's Date:	PCP:
Patient Name: (Last, First, Middle)	
Birth Date:	
Drug and Food Allergies :	Reaction:
Pharmacy Name:	

Do you have an Advanced Healthcare Directive? ❑ Medical Power of Attorney ❑ POLST ❑ None ❑ Don't Know

I HAVE BEEN TREATED FOR THE FOLLOWING: (check all that apply)

❑ Diabetes	❑ Bypass	❑ Blackout	❑ Thyroid Disorder	❑ STD Type:
❑ Hypertension	❑ Blood Clots	❑ Seizures	❑ Numbness	❑ Heart Attack
❑ Stroke	❑ Glaucoma	❑ Migraine	❑ Tremor	❑ Depression
❑ Amputation	❑ Breast Mass	❑ High Cholesterol	❑ Arthritis	❑ Anxiety
❑ Cancer	Type:______________	❑ Heartburn	❑ Broken Bone	❑ Bipolar
❑ Anemia	❑ COPD	❑ Ulcer	❑ Hepatitis	❑ Other
❑ Heart Disease	❑ Seizures	❑ Overactive Bladder	❑ HIV	❑

Medication you take (List milligrams and how many you take per day)	**Why are you taking it?**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.
11.	11.
12.	12.

Family History (Which family member had the following:) **Guide:** M=Mother F= Father B=Brother S=Sister MGM=Mat.Grandmother MGF=Mat.Grandfather PGM=Pat.Grandmother PGF=Pat. Grandfather	**Surgical History** (List operation and year performed:)
Diabetes	
Cancer	
Heart Disease	
Hypertension	
Stroke	
Anemia	
Other	

Social History

Hand Dominance: ❑Right ❑Left ❑Ambidextrous	Education Level Completed:
Military Experience ❑Yes ❑No What Branch :	Biohazard Exposure ❑Yes ❑No ❑Possible
Do you have children ❑Yes ❑No How Many: _______Boys_______Girls	Do you drink Alcohol? ❑Yes ❑No ❑Formerly _______drinks per day ________per week
Do you smoke ❑Yes ❑No ❑Formerly ❑Cannabis _______Packs per day ________Year Quit __________Number of years smoked	
Consume caffeine: ❑Yes ❑No ________Cups per day Type Consumed: ❑Coffee ❑Tea ❑Soda	
Housing Status: ❑Own ❑Rent ❑Homeless	
Who comprises your social network: ❑Family ❑Friends ❑Spouse/Partner ❑Other	
Activity Level: ❑Low ❑Medium ❑ High	
What type of exercise do you do:	
Hobbies/Activities:	
Diet History: ❑Normal ❑Special Diet-Please specify:	
Animals in the home? ❑Yes ❑No If yes, what type (circle all that apply) Birds Dogs Cats Rodents Reptiles Other ________________	
Do you clean up after animals? ❑Yes ❑ No	
Do you have guns in the home? ❑Yes ❑ No If so, are they locked? ❑Yes ❑No	
Is religion/spirituality an important part of your life? ❑Yes ❑No	
Do you agree to receive blood/blood products if necessary? ❑Yes ❑No	
Do you regularly travel out of the country? ❑Yes ❑No	

Thank you for your completion of this important information.

Patient/Responsible Party Signature____

Date___________________