VALLEY MEDICAL CENTER CLINIC NETWORK HEALTH QUESTIONNAIRE (ADULT)

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

Legal Name: *(Last, First, M.I.)*	**Date of Birth:**

PERSONAL MEDICAL HISTORY

Please place an "X" in the box that relates to your medical history

☐ Abnormal Pap	☐ Cancer, Prostate	☐ Erectile Dysfunction	☐ MRSA
☐ Alcohol Use Disorder	☐ Cancer, Skin	☐ GERD	☐ Myocardial Infarction
☐ Allergies, Environmental	☐ Chronic Kidney Disease	☐ Glaucoma	☐ Osteoporosis
☐ Anemia	☐ Chronic Pain	☐ Heart Murmur	☐ Peptic Ulcer Disease
☐ Anxiety	☐ Colon Polyps	☐ Hepatitis B	☐ Seizure Disorder
☐ Arthritis	☐ Congestive Heart Failure	☐ Hepatitis C	☐ Sleep Apnea – Obstructive
☐ Asthma	☐ COPD	☐ HIV/AIDS	☐ Stroke
☐ Atrial Fibrillation	☐ Coronary Artery Disease	☐ Hyperlipidemia	☐ Substance Use Disorder
☐ Bipolar Disorder	☐ Dementia	☐ Hypertension	☐ TIA
☐ BPH	☐ Depression	☐ Hypothyroidism	☐ Tuberculosis
☐ Cancer, Breast	☐ Diabetes Mellitus Type 1	☐ Irritable Bowel Syndrome	
☐ Cancer, Colon	☐ Diabetes Mellitus Type 2	☐ Kidney Stones	
☐ Cancer, Lung	☐ DVT	☐ Migraines	

List any other medical problems for you that we should know about:

Surgeries:

Surgery	Date	Surgery	Date

FAMILY HEALTH HISTORY

Please place an "X" in the box that relates to your family medical history

☐ I don't know my family history ☐ I am adopted

Relationship to Patient	NO KNOWN PROBLEMS	ALCOHOL ABUSE	ARTHRITIS	ASTHMA	BREAST CANCER	CANCER OF ANY KIND	CLOTTING DISORDER	COLON CANCER	COPD	DEPRESSION	DIABETES	HEART DISEASE	HEART FAILURE	HIGH CHOLESTEROL	HIGH BLOOD PRESSURE	KIDNEY DISEASE	LUNG CANCER	OSTEOPOROSIS	SLEEP APNEA	STROKE	SUBSTANCE ABUSE
Birth Mother																					
Birth Father																					
Siblings																					
Maternal Grandmother																					
Maternal Grandfather																					
Paternal Grandmother																					
Paternal Grandfather																					

List any other medical problems in your family that we should know about:

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Substance Use:				
Do you drink alcohol?	☐ Yes ☐ Not Currently ☐ Never	Number of drinks per week: Wine____ Beer____ Liquor____ Other:		
Do you use recreational drugs?	☐ Yes ☐ Not Currently ☐ Never	Substance:	Times a week:	
		Substance:	Times a week:	
Do you use tobacco?	☐ Never ☐ Former ☐ Every Day ☐ Some Days ☐ Unknown	☐ Cigarettes ☐ Pipe ☐ Cigar ☐ E-Cigarette	Start Date: ___________ Quit Date: ___________	
Cigarettes:	Packs Per Day: ___________ Years of Cigarette Use: ___________	Passive Smoke Exposure (Secondhand Smoke): ☐ Never ☐ Past ☐ Current		
Smokeless:	☐ Never ☐ Former ☐ Current ☐ Unknown	Quit Date:		

Sexual History:	
Sexually Active? ☐ Yes ☐ Not Currently ☐ Never	Gender(s) of Partner(s): ☐ Female ☐ Male Other: _______________
Birth Control/Protection Type:	

Socioeconomic:	
Current Occupation:	
Marital Status: ☐ Divorced ☐ Life Partner ☐ Married ☐ Registered Domestic Partner ☐ Separated ☐ Single ☐ Widowed ☐ Unknown	Number of Children:

Access & Resources (Social Determinants of Health):	
Transportation Concerns: In the past 12 months has lack of transportation kept you from medical appointments or from getting medications? In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?	☐Yes ☐No ☐ Prefer Not to Answer ☐Yes ☐No ☐ Prefer Not to Answer
Housing Concerns: In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time? In the last 12 months, how many places have you lived? # _______ In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?	☐Yes ☐No ☐ Prefer Not to Answer ☐Yes ☐No ☐ Prefer Not to Answer
Utility Concerns: Are you currently having concerns at home with your utilities such as your heat, electric, natural gas, or water?	☐ Often True ☐ Sometimes ☐ Never True ☐ Prefer Not to Answer
Food Concerns: Within the past 12 months, were you worried that your food would run out before you got the money to buy more? Within the past 12 months, the food you bought just didn't last and you didn't have money to get more?	☐ Never True ☐ Sometimes True ☐ Often True ☐ Prefer Not to Answer ☐ Never True ☐ Sometimes True ☐ Often True ☐ Prefer Not to Answer
If you answered Yes, Often, or Sometimes to any of the questions above: Would you like someone from our clinic to reach out to you with information about resources that may be able to help you? ☐Yes ☐No	
You can also search for resources using Valley Cares by going to https://valleycares.valleymed.org/	

Obstetric History (if applicable):			
Total Pregnancies: ________	Live births: _______________	Never Pregnant ☐	Currently Pregnant ☐

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Original Date:	2/14/2023
Dates Revised:	5/5/2023