UCS Healthcare
1300 Woodland Avenue, West Des Moines, IA 50265
Phone: 515-280-4930 / Fax 515-309-0686

Outpatient Health History Questionnaire

Office Notes

Name: **Birthdate:**

Preferred Name: **Work Phone:**

Who is your regular healthcare provider?

Address/phone:

When was the last time you were seen? How often do you go?

Who is your regular dentist?

Address/phone:

When was the last time you were seen? How often do you go?

Insurance: circle what type you have: HEALTH DENTAL EYE other_____

DAILY MEDICATIONS: Prescriptions; include strength, how often, and how many pills.
Also list all non-prescription medicines, vitamins, birth control, herbs, supplements, etc.

1) 4)

2) 5)

3) 6)

MEDICATION ALLERGIES:

Type of reaction:

OTHER ALLERGIES:
(bees/foods/latex etc.)

Type of reaction:

PAST MEDICAL HISTORY

List ongoing medical problems: (diabetes, heart, obesity, addictions, HIV, hepatitis, etc.)

1) 4)

2) 5)

3) 6)

Surgeries: (including dates)

1) 4)

2) 5)

3) 6)

IMMUNIZATIONS/VACCINATIONS/SHOTS

Last Tetanus_____ Last Flu_____ Last TB test_____, Results_____

Hepatitis A….. Yes/No #_____ Hepatitis B Yes/No #_____ HPV Yes/No #_____

SOCIAL HISTORY

I identify as: heterosexual, gay, lesbian, bi-sexual, pan-sexual, polyamorous, other_____

My birth sex: male, female, intersex, other_____ My legal sex: male female

I identify as: male female trans other_____ My preferred pronouns: he, she, ____

Single, Dating, Married, Long-Term Relationship(s), Widow/er, Divorced, Separated, _____

Patient Sex Listed on Insurance:

Spouse/Partner Name: Their Occupation:

Ages of Children: # of People in Household:

Your Occupation: Place Employed:

UCS Healthcare
1300 Woodland Avenue, West Des Moines, IA 50265
Phone: 515-280-4930 / Fax 515-309-0686

Outpatient Health History Questionnaire	Office Notes
I have good social support: (yes or no) Describe:_____	
Daily stresses I have include: health, money, job, transportation, education, childcare, legal	
What support groups do you go to? None or_____	
Are you or could you be pregnant? Last menstrual period_____	
Exercise: Yes / No what kind? how often?	
SOCIAL HISTORY	
Diet: describe: restrictions:	
Are you happy with your weight? Yes No	
Caffeine daily: Pop/soda daily:_____ ounces Diet or regular Energy drinks:	
Tobacco use: Daily amount: type:	
Circle the activities you participate in: Motorcycle Bicycle Ski/Snowboard Skateboard Do you wear a **helmet**? Always sometimes never N/A	
Have you been exposed to any **Toxic Substances**, such as asbestos, DES, radiation, chemicals? yes___ no___ if yes, please explain:	
Do you have a **smoke detector** at home? Y__N__ When was it last checked?	
Do you wear your seatbelt? Always___ Sometimes___ Never___	
Many people face violence in their lives, but never receive help, as no one ever asks them about it. We are here to help if you are in need of it assistance.	
Have you been in an abusive relationship? Yes No	
Does your partner ever hit you, hurt you, or threaten you in any way? Yes No	
Has your partner ever forced you to have sex when you didn't want to? Yes No	
Are you ever frightened of your partner? Yes No	
Has anyone ever hit you, hurt you, or threatened you in the past? Yes No	
MENTAL HEALTH	
Do you have any mental health issues? (circle) Depression, anxiety, post-traumatic stress disorder, bulimia, eating disorder, panic attacks, schizophrenia, other_____	
If you have a mental health therapist, who is it?	
Address/Phone:	
When was the last time you were seen? How often do you go?	
CIRCLE ONE: (My mental health issues are being taken care of) OR (I need to see someone)	
OTHER	
Have you had any sexually transmitted infections (STIs)? (circle any)	
Herpes, HIV/AIDS, gonorrhea, chlamydia, syphilis, warts, other:	
When was your last test for sexually transmitted infections?	
Do you have any health concerns related to your chemical use?	
Hepatitis, cirrhosis, liver failure, TB, HIV/AIDS, jaundice, STIs, bleeding, seizures,_____	
Have you exchanged sex for money, drugs, food, or shelter? Yes No	
Have you shared needles? Yes No	
HEALTH SCREENINGS: When was your last?	
PAP smear/pelvic exam:	
Cholesterol level:	
Colonoscopy (if over 50 years old)	
Mammograms	
Physical	

Client signature:_____ **Date**:_____