SIU MEDICINE
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# HEALTH HISTORY QUESTIONNAIRE

## SIU Medicine – Carbondale

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

SIU Center for Family Medicine
300 West Oak Street
Carbondale, IL 62901

Phone: (618) 536-6621
Fax: (618) 453-1102

| | | |
|---|---|---|
| **Name** *(Last, First, M.I.):* | ☐ Male ☐ Other ☐ Female | **DOB:** |
| **Marital status:** ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed | | |
| **Occupation:** | **Religious Preference:** | |
| **Previous doctor:** | **Date of last physical exam:** | |
| **Preferred Pharmacy:** | | |

## PERSONAL HEALTH HISTORY

| | | |
|---|---|---|
| **Childhood illness:** ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio | | |
| **Immunizations and dates:** | ☐ Tetanus | ☐ Pneumonia |
| | ☐ Hepatitis | ☐ Chickenpox |
| | ☐ Influenza | ☐ MMR (*Measles, Mumps, Rubella)* |

**List any medical problems that other doctors have diagnosed**

Specialists you are currently seeing:

**Surgeries**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Other Hospitalizations**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| Recent Procedures/Testing | Dates |
|---|---|
| Colonoscopy | |
| Pap Smear | |
| Mammogram | |
| Bone Density | |

Allergies to medications:

List any metal in your body:

| List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers | | |
|---|---|---|
| Name of Drug | Strength | Frequency Taken |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## 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 | ☐ High | ☐ Med | ☐ Low | | |
| **Caffeine** | ☐ None | ☐ Coffee | ☐ Tea | ☐ Cola | | |
| | # of cups/cans per day? | | | | | |
| **Alcohol** | Do you drink alcohol? | | | | ☐ Yes | ☐ No |
| | How many drinks per week? | | | | | |
| **Tobacco** | Do you use 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 |

## 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* | | |

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SIU Medical Record # _____

**AUTHORIZATION TO VERBALLY RELEASE MEDICAL INFORMATION TO PERSONS INVOLVED IN MY CARE**

Patient Name: _____ Date of Birth: _____
(PLEASE PRINT)

Daytime Phone: (___) _____

I hereby give SIU Medicine my permission to release my medical information to the individuals specified below, upon their request. Methods of release may include verbal discussions or updates about my medical treatment, medications, or condition as requested. The purpose for these disclosures is to enable the person(s) below to assist me in maintaining my health, and to participate in my medical care.

| Name | Relationship to Patient | Date |
|---|---|---|
| | | |
| Name | Relationship to Patient | Date |
| | | |

The information disclosed may include matters regarding mental health, developmental disability, alcohol or drug abuse and infectious diseases, including HIV, and medical correspondence. Please check and initial the box for which you will authorize disclosure of information; and sign below.

- ☐ _____ Mental Health
- ☐ _____ Developmental Disability
- ☐ _____ Alcohol or Drug Abuse
- ☐ _____ Infectious Diseases Including HIV
- ☐ _____ Medical Correspondence
- ☐ _____ Other

I understand that I may revoke this authorization at any time by notifying SIU Medicine in writing, but the revocation will not affect any actions taken prior to the receipt of the revocation. I understand this authorization will expire one year from the date of completion. SIU Medicine will request a new authorization form be completed annually.

In order to further protect your information, please identify a password and reminder question, to be used when the authorized person calls for information.

Password: _____

Reminder Question: _____

I hereby authorize the use or disclosure of my individually identifiable medical information as described above. I understand and acknowledge that the confidential healthcare information disclosed and used pursuant to this Authorization may be subject to re-disclosure by the person or organization authorized to receive the information and may no longer be protected by federal privacy regulations upon re-disclosure.

FORM MUST BE COMPLETED BEFORE SIGNING

| (Signature of Patient or Patient's Legal Representative) | Date of Birth | Date |
|---|---|---|
| | | |
| (Signature of Witness) | | Date |
| | | |

Printed name of Patient's Representative: _____

Relationship to Patient: _____

*Revised 03/17*

*(Facsimile reproductions of the signatures are acceptable)*

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## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO SIU MEDICINE

Patient Name _____ Health Record Number _____

Date of Birth _____ Telephone (___) _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure to SIU Medicine:

_____

Address: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

☐ Problem list
☐ List of allergies
☐ Most recent history and physical
☐ Medication list
☐ Immunization record
☐ Doctor/Specialty records only

☐ Laboratory results From (date) _____ to (date) _____
☐ X-ray and imaging reports From (date) _____ to (date) _____
☐ Consultation reports From (date) _____ to (date) _____
☐ Entire record From (date) _____ to (date) _____

☐ Other (Specify dates of service or other materials to be released) _____

_____

4. I authorize the release sensitive information as indicated:
*(The patient 12 or over, who consented to the treatment, must authorize the release of sensitive information.)*

☐ AIDS/HIV ☐ Drug/Alcohol Abuse ☐ Mental Health ☐ Genetic Information
☐ Sexual Assault ☐ Child Abuse ☐ Developmental Disabilities

4. Special Instructions: (e.g. appointment date or pick-up date/time/location) _____

_____

6. I understand the following provisions:

- I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits.
- I understand that I have the right to revoke this authorization at any time, in writing, and must deliver the revocation to the individual or organization providing the information.
- I understand that the revocation will not apply to information that has already been released in response to this authorization.
- Any disclosure of information has the potential for an unauthorized re-disclosure by the recipient and as such would no longer be protected by law**.
- If not otherwise specified, this authorization will expire six months after it is signed.
- I may inspect or copy the information to be used or disclosed as provided by law.

Signature of Patient or Consenting Individual _____ Date _____

If signature is not of Patient, indicate relationship _____ Date _____

Signature of Witness _____ Title _____ Date _____

**NOTICE TO RECEIVING AGENCY/FACILITY/PERSON: You may not re-disclose any records disclosed to you pursuant to the Illinois Mental Health and Developmental Disabilities Confidentiality Act (720 ILCS 110/ et seq.) or the federal Alcohol Drug Treatment regulations, (42 CFR 2 et seq.) unless the person who consented to this disclosure specifically consents to such re-disclosure.