GARD WELLNESS SOLUTIONS

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West Palm Beach, FL 33411
561.585.9619

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Address (street, city, zipcode):	
Phone:	**Email:**
Reason for today's visit:	
Do you have prescription insurance: ☐Yes ☐No	
Previous or referring doctor:	**Date of last physical exam:**

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

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

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)					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
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
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?				☐ Yes	☐ No
	Would you like information on the preparation of these?				☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ 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*		

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		

Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

FOR WEIGHT LOSS PATIENTS ONLY

Weight History:

When did you become overweight? ☐Childhood ☐Teen ☐Adulthood ☐Pregnancy ☐Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y/N | If Yes, how long ago?

Triggers for your weight gain (check all that apply):

☐Stress ☐Marriage ☐Divorce ☐Illness ☐Medication abuse ☐Travel ☐Injury

☐Nightshift work ☐Insomnia ☐Quitting (circle all that apply): Smoking / Alcohol / Drugs

What are your greatest challenges with dieting?

Have you ever taken medication to lose weight? (check all that apply)

☐Phentermine (Adipex) ☐ Meridia ☐Xenecal/Alli ☐ Phen/Fen

☐Phendimetrazine (Bontril) ☐Topamax ☐Saxenda ☐Diethylpropion

☐Bupropion (Wellbutrin) ☐Belviq ☐Qsymia ☐Contrave ☐Other:

What worked? | What didn't work?

Why or Why not?

Nutritional History:

Number of times a week you eat fast food: Breakfast_____ Lunch_____ Dinner_____

Eating Triggers (check all that apply):

☐Stress ☐Boredom ☐Anger ☐Seeking Reward ☐Parties ☐Eating Out ☐Fast Food ☐Other:

Food Cravings (check all that apply):

☐Sugar ☐Chocolate ☐Starches ☐Salty ☐High Fat ☐Large Portions ☐Favorite Foods:

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

GARD WELLNESS SOLUTIONS

Patient -Centered Healthcare+

Our goal is to be your partner with you in your health and offer you quality care. It is our goal to provide such care and coordinate your healthcare across all settings you may choose to receive. In order to be most effective, we need you to take an active role in your healthcare. It is your responsibility to provide a complete medical history as well as any information about care you receive outside of our practice. Please keep your provider informed of new medicines, allergies, hospitalizations, specialty visits, test results, and vaccines. We also treat the mind, body and soul. Prayer may be offered. GFMP does not guarantee healing or is held responsible for any supernatural occurrences that may occur.

Patient Portal

We offer you access to your own personal web portal where you can obtain your records and contact the office. The portal can be used to message your provider, request referrals and appointments, and manage your prescriptions. This portal is not for urgent issues, messages sent through the portal will not be checked until the next business day.

Prescriptions

In order to keep your records accurate and avoid potentially harmful drug interactions, we may need to verify your medications through an external database or with your pharmacist. This will allow your provider to know what medications other doctors or hospitals may have prescribed for you.

Laboratory and Test Results

Laboratory results or tests ordered at your visit may require an additional follow-up appointment with your provider to discuss results. Sensitive labs, such as HIV testing will always require a follow up with your provider.

Our Privacy Practices

In the course of providing healthcare to you, we may use and disclose your protected health information to carry out treatment at our healthcare facility, or for purposes that are permitted or required by law. Protected health information is information about you, that includes your demographic information that may be needed to help identify you and any past, present or future health conditions that may arise.

Some of the ways information could be used:

Appointment Reminders
Discuss Treatment Alternatives
Clinical Treatment Success and Written/Video Testimonials
Health Related Benefits and Services
Individuals involved in the Patient's care
Clinical Trials
As required by Law: to avert a serious threat of health or safety.
Organ and Tissue Donations
Military and Veterans
Worker's Compensation
Public Health Records
Lawsuits and Disputes
Coroners, Medical Examiners, Funeral Directors
Law Enforcement
National Security and Intelligence Agencies
Inmates

Other uses of information not covered by the laws that apply to us or our Privacy Practices will be made only with the patient's written permission.

For Weight Loss Patient's: Rules For Use of Anti-Obesity Control Medications

I have read through the rules of the anti-obesity controlled medications and have understood and agreed to the terms of medication usage. It is my responsibility to follow the instructions carefully.

Signature_____ Date_____

Consent to Leave Phone / Text Messages

I understand that as part of my healthcare, Gard Family Medical Practice (GFMP) may need to reach me by phone.

☐ I DO authorize them to leave a text message on ☐ my telephone for appointment reminders and phone calls regarding lab tests/results and imaging studies. **However, I understand that sensitive information and or results that will require medication follow-up or discussion will require that I make an appointment with the physician.**

☐ I DO NOT authorize them to leave any messages on my telephone regarding any type of testing results or appointment reminders. **I will accept the responsibility of making an appointment with the physician to obtain results.**

I hereby give consent to my health care provider to discuss or release my private health care information to (i.e. Spouse, Parent, Care-taker):
Name: _____ Relationship to Patient:_____
Name: _____ Relationship to Patient:_____

I hereby consent that I will not use any recording device of voice or image on the premise of GFMP, this includes items such as cameras, voice recorders, phones and google glasses.

Financial Responsibility

The following information provided is to make clear financial responsibilities of the patient and help with any misunderstandings concerning payment of services.

We do not accept insurance, so you are considered Self Pay. This means payment is due at the time service is rendered.

Referrals

Please allow 3 business days from the date requested.

Labs

Please be aware that any blood work or pathology will be billed separately from an office visit. These will be directly billed to you by the lab company.

Release of Liability

Gard Family Medical Practice does not carry malpractice insurance. I assume all risks associated with treatment and care at Gard Family Medical Practice (GFMP) and hereby release, absolve, and agree to hold harmless GFMP or any of its employees. Nor will any of the said employees be held financially responsible or legally responsible for any injury, loss, damage, illness or death attributed to unforeseen circumstances that are beyond their control or that may arise out of my failure to follow general instructions and guidelines.

My signature confirms my responsibilities as a patient and my understanding of Gard Family Medical Practices' Policies and Procedures presented in my registration packet.

Signature_____ Date_____

Print Name_____

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I, _____, authorize Bryan L. Gard, PA-C and associated health care providers, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction on behavior modification techniques, and may involve the use of anti-obesity medications. Other treatment options may include a very low-calorie diet or a protein supplemented diet. I further understand that if medications are used, they have been used safely and successfully in private medical practices with experienced obesity medicine specialists as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with having excess weight or obesity. Risks of this program are usually temporary, reversible, and may include but are not limited to nervousness, sleeplessness, headaches, electrolyte abnormalities, dry mouth, gastrointestinal disturbances, weakness, fatigue, pancreatitis, psychological problems, gallstones, high blood pressure, rapid or slowing of the heartbeat and heart irregularities, and risk of weight regain. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints, including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight but will increase with additional weight gain over time.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees that the program will be successful. I also understand that obesity is a chronic, lifelong condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and it has been fully explained to me. My questions have been answered to my complete satisfaction.

_____ _____

Patient's Name (printed) Date

_____

Patient Signature
(or signature of person with authority to consent for patient)