Patient History Summary

Q: What is your full name?

A: yes

Q: What is your date of birth?

A: V

Q: What gender do you identify as?

A: V

Q: What is your preferred language for speaking?

A: V

Q: What is your preferred language for reading?

A: V

Q: Are you able to read without difficulty?

A: V

Q: What is your current address?

A: V

Q: What is your phone number?

A: V

Q: What is your email address?

A: V

Q: How many children under 18 live with you?

A: V

Q: How many adults live in your household (excluding you)?

A: V

Q: What is your living environment? (e.g., city, suburb, rural)?

A: V

Q: What is the highest level of education you have completed?

A: V

Q: How do you prefer to learn health information?

A: V

Q: Do you have any challenges that affect your ability to learn or communicate (e.g., vision, hearing, cognitive issues)?

A: V

Q: Have you ever been diagnosed with any of the following conditions? (diabetes, asthma, cancer, etc.)?

A: V

Q: What medications are you currently taking?

A: V

Q: Have you had any hospitalizations in the past year?

A: V

Q: Have you had any surgeries in the past year?

A: V

Q: Do you experience chronic pain? If so, where?

A: V

Q: Does anyone in your family have a history of heart disease?

A: V

Q: Does anyone in your family have a history of cancer?

A: V

Q: Does anyone in your family have a history of mental health conditions?

A: V

Q: Does anyone in your family have a history of diabetes?

A: V

Q: Has anyone in your immediate family died of a hereditary illness?

A: V

Q: What is your current occupation?

A: V

Q: Do you smoke or use tobacco products? If so, how often?

A: V

Q: Do you consume alcohol? If so, how often?

A: V

Q: Do you use recreational drugs? If so, how often?

A: V

Q: Do you have any dietary restrictions?

A: V

Q: Do you exercise regularly? How many days a week?

A: V

Q: How would you rate your current emotional wellbeing? (Excellent, Good, Fair, Poor)?

A: V

Q: Have you ever been diagnosed or treated for a mental health condition?

A: V

Q: Have you felt anxious, depressed, or hopeless in the last 2 weeks?

A: V

Q: Have you ever tested positive for COVID-19?

A: V

Q: Did you experience long-term symptoms such as fatigue, brain fog, or breathing issues?

A: V

Q: Do you still experience any COVID-related symptoms today?

A: V

Q: Do you have a primary care provider?

A: V

Q: How long have you been seeing your primary care provider?

A: V

Q: Are you following a care plan created with a doctor?

A: V

Q: Are your medications reviewed regularly by a healthcare professional?

A: V

Q: Do you feel confident managing your own health?

A: V

Q: Do you need assistance from others to manage your health (e.g., emotional, financial, physical)?

A: V

Q: Do you have insurance that covers your current health needs?

A: V