Patient History Summary

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Basic Information

Q2: What is your full name?

A2: gf

Q3: What is your date of birth?

A3: g

Q4: What gender do you identify as?

A4: g

Q5: What is your preferred language, if any?

A5: g

Q6: What is your preferred method of communication? (e.g., phone, email, in-person)

A6: g

Medical Background

Q7: Do you have any allergies or chronic conditions? If so, please list them.

A7: g

Q8: Do you have any current symptoms or concerns?

A8: g

Q9: Do you have any disabilities? If so, please describe them.

A9: g

Q10: Have you had any surgeries in the past? If so, please list them.

A10: g

Q11: Have you had any hospitalizations in the past? If so, please list them.

A11: g

Q12: Have you had any major illnesses in the past? If so, please list them.

A12: g

Q13: Do you have any family history of major illnesses? If so, please list them.

A13: g

Q14: Do you have any history of mental health conditions, substance abuse, domestic violence or abuse, sexual abuse, PTSD, self-harm, eating disorders, sleep disorders, chronic pain, heart disease, or any other illnesses? If so, please describe them.

A14: g

Behavioral and Mental Health

Q15: Do you smoke or use tobacco products? If so, how often?

A15: g

Q16: Do you consume alcohol? If so, how often?

A16: g

Q17: Do you use recreational drugs? If so, how often?

A17: g

Q18: Do you have any dietary restrictions?

A18: g

Q19: Have you ever been diagnosed or treated for a mental health condition?

A19: g

Q20: Have you felt anxious, depressed, or hopeless in the last 2 weeks?

A20: g

COVID-19 History

Q21: Have you ever tested positive for COVID-19?

A21: g

Q22: Did you experience long-term symptoms such as fatigue, brain fog, or breathing issues?

A22: g

Q23: Do you still experience any COVID-related symptoms today?

A23: g

Care Management

Q24: Do you have a primary care provider?

A24: g

Q25: How long have you been seeing your primary care provider?

A25: g

Q26: Are you following a care plan created with a doctor?

A26: g

Q27: Are your medications reviewed regularly by a healthcare professional?

A27: g

Self-Management & Support

Q28: Do you feel confident managing your own health?

A28: g

Q29: Do you need assistance from others to manage your health (e.g., emotional, financial, physical)?

A29: g

Q30: Do you have insurance that covers your current health needs?

A30: g

Insurance

Q30: Do you have insurance that covers your current health needs?

A30: g