Patient History Summary

Q: Are you ready to get your medical history recorded?

A: asdf

Q: What is your full name?

A: asdf

Q: What is your date of birth?

A: asdf

Q: What gender do you identify as?

A: asdf

Q: What is your preferred language for speaking?

A: asdf

Q: What is your preferred language for reading?

A: asdf

Q: What is your preferred language for writing?

A: asdf

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

A: asdf

Q: Do you have any allergies? If so, please list them.

A: asdf

Q: Do you have any chronic conditions? If so, please list them.

A: asdf

Q: Do you have any current symptoms or concerns?

A: asdf

Q: What is your emergency contact's name?

A: asd

Q: What is your emergency contact's relationship to you?

A: fasdf

Q: What is your emergency contact's phone number?

A: asdf

Q: What is your emergency contact's email address?

A: asdf

Q: Do you have a preferred pharmacy? If so, please provide the name and address.

A: asdf

Q: Do you have any health insurance? If so, please provide the name of the provider.

A: asdf

Q: What is your health insurance policy number?

A: asdf

Q: What is your health insurance group number?

A: asdf

Q: What is your occupation?

A: asdf

Q: What is your current employment status? (e.g., employed, unemployed, retired)

A: asdf

Q: What is your highest level of education?

A: asdf

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

A: asdf

Q: Do you have any special needs or accommodations that we should be aware of?

A: asdf

Q: Do you have any cultural or religious beliefs that may affect your healthcare?

A: asdf

Q: Do you have any pets? If so, please list them.

A: asdf

Q: Do you have any dietary restrictions? If so, please list them.

A: asdf

Q: Do you have any specific health goals or concerns that you would like to address?

A: asdf

Q: Do you have a primary care provider? If so, please provide their name and contact information.

A: asdf

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

A: asdf

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

A: asdf

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

A: asdf

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

A: asdf

Q: Do you have any current medications? If so, please list them.

A: asdf

Q: Do you have any past medications that you have taken? If so, please list them.

A: asdf

Q: Do you have any allergies to medications? If so, please list them.

A: asdf

Q: Do you have any allergies to foods? If so, please list them.

A: asdf

Q: Do you have any allergies to environmental factors? If so, please list them.

A: asdf

Q: Do you have any history of mental health conditions? If so, please describe them.

A: asdf

Q: Do you have any history of substance abuse? If so, please describe it.

A: asdf

Q: Do you have any history of domestic violence or abuse? If so, please describe it.

A: asdf

Q: Do you have any history of sexual abuse or assault? If so, please describe it.

A: asdf

Q: Do you have any history of trauma or PTSD? If so, please describe it.

A: asdf

Q: Do you have any history of self-harm or suicidal thoughts? If so, please describe it.

A: asdf

Q: Do you have any history of eating disorders? If so, please describe it.

A: asdf

Q: Do you have any history of sleep disorders? If so, please describe it.

A: asdf

Q: Do you have any history of chronic pain? If so, please describe it.

A: asdf

Q: Do you have any history of heart disease? If so, please describe it.

A: asdf

Q: Do you have any history of lung disease? If so, please describe it.

A: asdf

Q: Do you have any history of liver disease? If so, please describe it.

A: asdf

Q: Do you have any history of kidney disease? If so, please describe it.

A: asdf

Q: Do you have any history of gastrointestinal disease? If so, please describe it.

A: yes

Q: Do you have any history of neurological disease? If so, please describe it.

A: yes

Q: Do you have any history of autoimmune disease? If so, please describe it.

A: yes

Q: Do you have any history of cancer? If so, please describe it.

A: yes

Q: Do you have any history of diabetes? If so, please describe it.

A: yes

Q: Do you have any history of hypertension? If so, please describe it.

A: yes

Q: Do you have any history of high cholesterol? If so, please describe it.

A: yes

Q: Do you have any history of stroke? If so, please describe it.

A: yes

Q: Do you have any history of seizures? If so, please describe it.

A: yes

Q: Do you have any history of thyroid disease? If so, please describe it.

A: yes

Q: Do you have any history of asthma or other respiratory conditions? If so, please describe it.

A: yes

Q: Do you have any history of allergies or allergic reactions? If so, please describe it.

A: yes

Q: Do you have any history of skin conditions? If so, please describe it.

A: yes

Q: Do you have any history of eye conditions? If so, please describe it.

A: yes

Q: Do you have any history of hearing conditions? If so, please describe it.

A: yes