

DOMENICK BRACCIA, D.O.
Haverford Wellness Center
345 Main Street, Suite 4, Harleysville, PA 19438
215 256 0050 phone/215 256 0059 fax
email: haverfordwellness@verizon.net

CONFIDENTIAL HEALTH QUESTIONNAIRE
(PLEASE FAX/EMAIL/OR MAIL TO OUR OFFICE PRIOR TO YOUR APPT)

Today's Date _____ Soc. Sec. No. _____

Name _____ Date of Birth _____

Spouse's Name OR Parent's Names (if patient is a minor) _____

_____yrs Married _____Divorced _____Single _____Separated

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax _____ Email _____

Pharmacy Name _____ Phone # _____ Fax # _____

Emergency Contact _____ Phone _____

Occupation _____ Race _____ Ethnicity _____

How did you hear about our office? _____

MEDICAL HISTORY

Main reason for appointment:

Known Allergies to Medication:

Patient Name: _____
Date of Birth: _____

List Current Medications (including dosages, # of caps or tabs taken daily):

List Injuries (including date when injury occurred):

List Current Supplements (including dosages, # of caps or tabs taken daily)

Current Medical History of Patient (Check all that apply)

Signs/Symptoms:

- Abnormal Heart Sounds Blood Pressure Reading Elevated Cough Diarrhea
- Cachexia (weight loss, muscle atrophy, fatigue, weakness, loss of appetite) Heartburn
- Hepatomegaly (enlarged liver) Incontinence urine/feces Lack of Coordination Murmur
- Nausea Nausea with Vomiting Shortness of Breath Speech Disturbance
- Tension Headache Viremia (Presence of viruses in the blood) Weight Loss Other: _____

Patient Name: _____
Date of Birth: _____

Current & Past Medical History of Patient (check all that apply)

Cardiovascular:

___ Abnormal Aortic Aneurysm ___ Abnormal Electrocardiogram ___ Angina stable or unstable ___ Aortic Stenosis
___ Atherosclerosis ___ Atrial Fibrillation ___ Atrial Flutter ___ Atrioventricular Block
___ Congestive Heart Failure ___ Coronary Heart Failure ___ Heart Disease ___ Heart Failure
___ Hypertension ___ Hypertensive Heart Disease ___ Other: _____

Respiratory:

___ Asthma ___ Bronchitis (Acute or Chronic) ___ Pneumonia (Bacterial or Viral) ___ Rhinitis (Allergic or
Chronic) ___ Sinusitis, Chronic ___ Other: _____

Digestive:

___ Appendicitis ___ Blood in Stool ___ Celiac Disease ___ Colitis, ulcerative ___ Colon
___ Constipation ___ Diverticula of Intestine ___ Esophageal Reflux ___ Hemorrhoids ___ Hepatitis
___ Hepatitis Chronic or Alcohol ___ Hernia ___ Irritable Bowel Syndrome ___ Liver Disorder
___ Rectal Bleeding ___ Stomach, Functional Disorder ___ Vomiting ___ Other: _____

Endocrine:

___ Anorexia ___ Autoimmune Disease ___ Chronic Fatigue Syndrome ___ Cystic Fibrosis
___ Diabetes II (orals) ___ Diabetes I (injectible) ___ Endocrine Disorder ___ Goiter
___ Hypercholesterolemia ___ Hyperlipidemia ___ Hyperthyroidism ___ Hypothyroidism (Acquired or
Congenital) ___ Immunologic Disorder ___ Metabolic Disorder ___ Morbid Obesity ___ Nutritional
Deficiency ___ Obesity ___ Ovarian Dysfunction ___ Pituitary Gland Disorder ___ Rickets, Acute
___ Thyroiditis ___ Weight Gain Abnormal ___ Other: _____

Patient Name: _____
Date of Birth: _____

Neurologic:

____ Alzheimer's Disease ____ Common Migraines ____ Convulsions ____ Encephalitis ____ Gait Abnormality
____ Headache ____ Meningitis ____ Meningitis (Bacterial or Viral) ____ Mild Cognitive Impairment
____ Motor Neuron Disease ____ Multiple Sclerosis ____ Muscle Weakness ____ Neurologic Disorders
____ Neuropathy ____ Parkinsonism, Secondary ____ Post Stroke Paralysis ____ Post Infectious Encephalitis
____ Progressive Musclar Atrophy ____ Sleep Disorder ____ Spinal Cord Disorder ____ Spinal Muscle Atrophy
____ Transient Ischematic Attack (TIA) ____ Other: _____

Renal/GU:

____ Chronic Interstitial Cystitis ____ Chronic Kidney Disease ____ Chronic Renal Failure ____ Cystitis
____ Diabetes Nephropathy ____ HIV, infection ____ Urinary Incontinence
____ Other: _____

Hematologic:

____ Anemia ____ Specific Type of Anemia _____
____ Coagulation Defect ____ Hematological Disorder ____ White Blood Cell Disorder
____ Other: _____

Musculoskeletal:

____ Arthritis ____ Backache ____ Bone Infection ____ Bunion ____ Joint Disorder ____ Joint Pain
____ Muscular Spasm ____ Musculoskeletal Deformity, Aquired ____ Osteopenia ____ Osteoporosis
____ Periostitis ____ Sciatica ____ Sprain and Strain ____ TMJ ____ Other: _____

Breast:

____ Abnormal Mammogram ____ Other: _____

Patient Name: _____
Date of Birth: _____

Skin:

___ Acne ___ Eczema ___ Edema ___ Malignant Melanoma of Skin ___ Scleroderma ___ Other: _____

Psychiatry:

___ Acute reaction to stress ___ Alcohol Withdrawal ___ Bipolar ___ Major Depression (recurrent) ___ Major Depression (single episode) ___ Manic Affective Disorder ___ Mental Retardation ___ Neurotic Depression ___ Panic Disorder ___ Schizophrenia ___ Other: _____

Patient Surgical History: Please include type of surgery and year it was performed.

Patient's Family History

If family members have any of the following please identify which by the following: (Mother = **M**, Father = **F**; Brother = **B**; Sister = **S**; Grandmother (Maternal) = **GMM**; Grandmother (Paternal) **GMP**; Grandfather (Maternal) **GFM**; Grandfather (Paternal) **GFP**; Child = **C**; Aunt = **A**; Uncle = **U**)

- | | | |
|-------------------------------|-----------------------------|-------------------------------|
| 1. ___ Back Problems | 6. ___ Ulcers | 11. ___ High Blood Pressure |
| 2. ___ Gall bladder Trouble | 7. ___ Rheumatic fever | 12. ___ Lyme Disease |
| 3. ___ Seizures | 8. ___ Elevated Cholesterol | 13. ___ Cancer: Type _____ |
| 4. ___ Diabetes | 9. ___ Thyroid Disease | 14. ___ Liver Disease |
| 5. ___ Heart Disease Problems | 10. ___ Heart Attack | 15. ___ Stroke 16. ___ Kidney |

Please indicate past or present amounts:

Daily Weekly Occasionally Never Past

Coffee/Caffeine

Tobacco (packs/day)

Alcohol (drinks per day/per week)

Recreational Drugs