



# MINI HEALTH HISTORY QUESTIONNAIRE

Please bring this completed form to your St John's Internal Medicine Appointment

Answer each question by printing the necessary information. Your answers are confidential as protected by Federal HIPPA regulations.

### PERSONAL INFORMATION:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address : \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

In case of emergency, please notify:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### MEDICAL INFORMATION:

Primary Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you under the care of a physician, chiropractor, or other health care professional? Yes  No

If yes, list reason: \_\_\_\_\_

Are you taking any medications? Yes  No  ALLERGIES: \_\_\_\_\_

Please describe any medical diagnoses and medications prescribed:

<i>Diagnosis</i>	<i>Drug</i>	<i>Dosage</i>	<i>Frequency</i>	<i>Diagnosis</i>	<i>Drug</i>	<i>Dosage</i>	<i>Frequency</i>
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Have you had any surgery or new medical diagnosis made since your last Fire/EMS examination?

Yes  No

If yes, please list here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any concerns about your health that you would like to address today? Yes  No

**IMMUNIZATION HISTORY:**

Hep B series given \_\_\_\_\_ Titers checked \_\_\_\_\_  
MMR Titer Results \_\_\_\_\_, Tetanus \_\_\_\_\_, Seasonal Flu \_\_\_\_\_

**EXERCISE HABITS:**

*Please check the box that best describes your work and exercise habits:*

- |   |  |
|---|--|
| <input type="checkbox"/> Intense occupational and recreational exertion   | <input type="checkbox"/> Sedentary work and moderate recreational exertion |
| <input type="checkbox"/> Moderate occupational and recreational exertion  | <input type="checkbox"/> Sedentary work and light recreational exertion    |
| <input type="checkbox"/> Sedentary work and intense recreational exertion | <input type="checkbox"/> Complete lack of all exertion                     |

**Are you currently involved in a regular exercise program?** Yes  No

**Do you regularly walk or run 1 or more miles continuously?** Yes  No   
*If yes, what is the average number of miles you cover in a workout? \_\_\_\_\_*  
*What is your average time per mile? \_\_\_\_\_*

**Do you practice weightlifting?** Yes  No

**Are you involved in an aerobics program?** Yes  No   
*If yes, what type(s)? \_\_\_\_\_*

**What activities would you prefer in a regular exercise program for yourself?**  
\_\_\_\_\_

**Do you have a bone/joint problem that has been or could be made worse by exercise?** Yes  No

**Are you unaccustomed to vigorous exercise?** Yes  No

**Is there any reason not mentioned here why you can not follow a regular exercise program?** Yes  No   
*If so, please explain \_\_\_\_\_*

**ADVANCE DIRECTIVE**

Do you have an advanced directive? Where is a copy stored? \_\_\_\_\_

**CERTIFICATION**

The above information is true to the best of my knowledge.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_  
Name

PRINT: \_\_\_\_\_  
Name

**DISCLAIMER:** This information can be discussed with/released to the Medical Director of Jackson Hole Fire/EMS.

**REVIEWED BY MEDICAL PROVIDER**

SIGNED: \_\_\_\_\_  
Name

DATED: \_\_\_\_\_

PINTED: \_\_\_\_\_  
Name