Patient Name:_____ Date of Birth:_____ Gender:_____

Today's Date:_____ Primary Care Provider (PCP)/Doctor Name:_____

Comprehensive Health Assessment Questionnaire (CHA-Q)

Please complete this Health Assessment to the best of your knowledge and bring a copy to your scheduled appointment.

Medical History

In the past year, have you been hospitalized or had a major operation? ☐Yes ☐No

IF yes, please explain:

_____

_____

Are you taking any medications, pills or drugs? ☐Yes ☐No

IF yes, please describe if you are experiencing any unwanted side effects OR if you are having trouble taking a medication as prescribed, please explain why:

_____

_____

_____

_____

_____

Do you have, or does your family have a history of?

	Me	Family Member (Mom, Dad, Brother/Sister)
Asthma	☐Yes ☐No	☐Yes ☐No
Alcohol Addiction	☐Yes ☐No	☐Yes ☐No
Cancer	☐Yes ☐No	☐Yes ☐No
Depression	☐Yes ☐No	☐Yes ☐No
Diabetes	☐Yes ☐No	☐Yes ☐No
Drug Addiction	☐Yes ☐No	☐Yes ☐No
Epilepsy or Seizures	☐Yes ☐No	☐Yes ☐No
Frequent Headaches	☐Yes ☐No	☐Yes ☐No
Heart Attack/Failure	☐Yes ☐No	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	☐Yes ☐No
High Cholesterol	☐Yes ☐No	☐Yes ☐No
Kidney Problems	☐Yes ☐No	☐Yes ☐No
Osteoporosis	☐Yes ☐No	☐Yes ☐No
Psychiatric Care	☐Yes ☐No	☐Yes ☐No
Shingles	☐Yes ☐No	☐Yes ☐No
Sickle Cell Disease	☐Yes ☐No	☐Yes ☐No
Stress	☐Yes ☐No	☐Yes ☐No
Stroke	☐Yes ☐No	☐Yes ☐No
Ulcers	☐Yes ☐No	☐Yes ☐No

Family/Social/Cultural Characteristics

Do you have trouble finding support from the people that are closest to you to help manage your health?

☐Yes, Currently ☐Yes, In the Past ☐No/Never

IF yes, please explain:

_____

_____

Communication Needs

Do you have any trouble communicating with others due to your ability to hear, see or your mental clarity?

☐Yes, Currently ☐Yes, In the Past ☐No/Never

IF yes, please explain:

_____

_____

Social Functioning

Do you have any trouble interacting with other people in everyday social tasks or maintaining a social life?

☐Yes, Currently ☐Yes, In the Past ☐No/Never

IF yes, please explain:

_____

_____

Social Determinants of Health

Do you ever need help reading materials given to you by your doctor?

☐Yes, Currently ☐Yes, In the Past ☐No/Never

IF yes, please explain:

_____

_____

Do finances affect your ability to manage your health care?

☐Yes, Currently ☐Yes, In the Past ☐No/Never

IF yes, please explain:

_____

_____

Behaviors Affecting Health

Do you feel you have a well-balanced diet that includes fruits and vegetables? ☐Yes ☐No

How would you describe the general condition of your mouth and teeth? ☐Excellent ☐Good ☐Fair ☐ Poor