

# Interval History Questionnaire

*The Care Group, P.C.*

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Today's Date \_\_\_\_\_

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Thank you for completing this form. It will help us to better serve your health care needs today.

Name \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

\_\_\_\_\_

## ***Since your last physical exam:***

Has anything in your medical history changed? YES NO

If YES, describe: \_\_\_\_\_

\_\_\_\_\_

Has anything in your family history changed (mother, father, siblings)? YES NO

If YES, describe: \_\_\_\_\_

\_\_\_\_\_

Have you been hospitalized or had surgery? YES NO

If YES, describe: \_\_\_\_\_

\_\_\_\_\_

Have you seen any other health care providers (including chiropractor, etc) ? YES NO

If YES, describe: \_\_\_\_\_

\_\_\_\_\_

**List all of your medications.** Please include dosage and frequency and any other over the counter and herbal medication or supplements that you are taking:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you developed any new allergies? YES NO

If YES, please include type of reaction: \_\_\_\_\_

Do you have an advanced directive (living will or Healthcare Power of Attorney) ? YES NO

If YES, where is it on file? \_\_\_\_\_