

Adult Health History Questionnaire:

Name _____ Date of birth _____

Address _____

Local phone number _____ Alternative phone number _____

Please describe what problem or concern brought you to our office today:

Primarily to establish care Other (please briefly describe) _____

Special Communication Needs:

Language preference:

If 'yes' to any of the questions below, how can we assist?

Visual impairment Yes No

Hearing impairment Yes No

Speech impairment Yes No

Cognitive impairment Yes No

Sensory impairment Yes No

Personal Health History

Please check past(P) or current(C) problems or conditions

Hypertension Bowel/digestive problem

High cholesterol Atrial Fibrillation

Diabetes Seizures

Heart attack or angina Headaches

Irregular heart rhythm Stroke

Congestive heart failure Prostate problem

Emphysema or chronic bronchitis Breast problem

Pneumonia Urinary tract infections

Gastroesophageal reflux disease Arthritis

Asthma Thyroid problem

Osteoporosis/Osteopenia Bleeding disorder

Cancer, Type: Addiction Issues

Stomach ulcer Depression

Kidney Disease, Type: Anxiety

Liver Disease, Type: Mental Illness

Other: _____

Previous Surgical Procedures

Please check if you have had any of the following

Procedure	Year
<input type="checkbox"/> Heart surgery	
<input type="checkbox"/> Carotid artery surgery	
<input type="checkbox"/> Vascular surgery / stent	
<input type="checkbox"/> Abdominal aneurysm repair	
<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Gallbladder removed	
<input type="checkbox"/> Appendix removed	
<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Joint replacement <input type="checkbox"/> Hip <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Knee <input type="checkbox"/> Right <input type="checkbox"/> Left	
<input type="checkbox"/> Spine Surgery <input type="checkbox"/> Neck <input type="checkbox"/> Back	
<input type="checkbox"/> Breast cancer surgery	
<input type="checkbox"/> Prostate cancer surgery	
<input type="checkbox"/> Hernia	
<input type="checkbox"/> Other: _____	

Social History:

Marital status: Single Married Divorced Widowed Life Partner

Live here year round? Yes No If no, Part time location: _____

Occupation: _____ **Concerns:** Stress Hazardous substances Heavy lifting

Tobacco use: Never Quit (when) _____ Current smoker: Packs/day, how many years _____

Alcohol use: No Yes If yes how many drinks/how often _____

Caffeine use: No Yes If yes, Coffee Soda Tea how many drinks/how often _____

Illicit Drug use (including marijuana, cocaine, steroids): Never Past Current

Describe: _____

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

<input type="checkbox"/> Chest pain	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Black/tarry stools	<input type="checkbox"/> Loss of vision	<input type="checkbox"/> Pain in testicles
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Double vision	<input type="checkbox"/> Loss of libido
<input type="checkbox"/> Cough	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Impotence
<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Breast pain
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Pain in ears	<input type="checkbox"/> Breast discharge
<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Other (please describe below)
<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Constipation	<input type="checkbox"/> Hoarseness	
<input type="checkbox"/> Fast heartbeat	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Easy bleeding	
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Easy bruising	
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Urine frequency	<input type="checkbox"/> Rash	
<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Decrease in urine flow	<input type="checkbox"/> Changes in mole	Females - Please complete
<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> Urine leakage	<input type="checkbox"/> Sore that won't heal	Menstrual flow:
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Headaches, frequent	<input type="checkbox"/> Fatigue/lethargy	<input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. <input type="checkbox"/> Pain/cramps
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Insomnia	Days of flow ___ Length of cycle ___
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Loss of strength	<input type="checkbox"/> Forgetfulness	1st day of last period _____
<input type="checkbox"/> Ankle swelling	<input type="checkbox"/> Balance problems	<input type="checkbox"/> Depression	<input type="checkbox"/> Pain or bleeding after sex
<input type="checkbox"/> Nausea	Pain, weakness, or numbness in		Number of pregnancies _____
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Arms	<input type="checkbox"/> Hips	<input type="checkbox"/> Back
<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Legs	<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulders
<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Hands	<input type="checkbox"/> Feet	<input type="checkbox"/> Abdomen
			Menopause <input type="checkbox"/> Y <input type="checkbox"/> N Age: _____

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically, have any of your relatives had the following conditions:

Condition	Relative	Condition	Relative
<input type="checkbox"/> Mental illness		<input type="checkbox"/> Chemical dependency	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Thyroid Disease		<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Pituitary Disease		<input type="checkbox"/> Dementia	
<input type="checkbox"/> Crohn's/Colitis		<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Cancer, Type: _____		<input type="checkbox"/> Other:	

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Health Maintenance:

Please check whether you have had the following preventive services and enter the year of the service

Immunizations	Last Occurrence	Tests	Last Occurrence
Tetanus vaccine / Tdap <input type="checkbox"/> Yes <input type="checkbox"/> No		Pap smear/pelvic <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pneumonia vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No		Mammogram <input type="checkbox"/> Yes <input type="checkbox"/> No	
Influenza vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No		Bone Density <input type="checkbox"/> Yes <input type="checkbox"/> No	
Shingles vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No		Colonoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> Yes <input type="checkbox"/> No		Prostate test <input type="checkbox"/> Yes <input type="checkbox"/> No	
Guardasil (HPV) <input type="checkbox"/> Yes <input type="checkbox"/> No		Chest X-Ray <input type="checkbox"/> Yes <input type="checkbox"/> No	

Hospital Admissions (excluding pregnancies):

Date	Hospital	Reason for admission

Allergies:

Please list any allergies to medications or foods

Name	Symptom/Reaction

Medications:

Please list any medications that you take including over the counter medications, herbs, and supplements.

Name	Dose	Freq.	Name	Dose	Freq.

Pharmacy: _____ Phone: _____ Store #: _____

Location Description: _____

Specialty Providers:

In order that we can best coordinate your care, please list any medical providers you see outside of this practice

Cardiologist

Name: _____

Phone: _____ Last Seen: _____

Nephrologist

Name: _____

Phone: _____ Last Seen: _____

Ophthalmologist

Name: _____

Phone: _____ Last Seen: _____

Psychiatrist/Psychologist

Name: _____

Phone: _____ Last Seen: _____

Oncologist

Name: _____

Phone: _____ Last Seen: _____

Allergist

Name: _____

Phone: _____ Last Seen: _____

Urologist

Name: _____

Phone: _____ Last Seen: _____

Gynecologist

Name: _____

Phone: _____ Last Seen: _____

Gastroenterologist

Name: _____

Phone: _____ Last Seen: _____

Pulmonologist

Name: _____

Phone: _____ Last Seen: _____

Endocrinologist

Name: _____

Phone: _____ Last Seen: _____

Podiatrist: _____

Name: _____

Phone: _____ Last Seen: _____

Other: _____

Name: _____

Phone: _____ Last Seen: _____

Other: _____

Name: _____

Phone: _____ Last Seen: _____

Patient/Guardian Signature: _____ Date: _____