

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hearing impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Speech impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cognitive impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sensory impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Personal Health History

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

<input type="checkbox"/> <input type="checkbox"/> Hypertension	<input type="checkbox"/> <input type="checkbox"/> Bowel/digestive problem
<input type="checkbox"/> <input type="checkbox"/> High cholesterol	<input type="checkbox"/> <input type="checkbox"/> Atrial Fibrillation
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Seizures
<input type="checkbox"/> <input type="checkbox"/> Heart attack or angina	<input type="checkbox"/> <input type="checkbox"/> Headaches
<input type="checkbox"/> <input type="checkbox"/> Irregular heart rhythm	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> <input type="checkbox"/> Prostate problem
<input type="checkbox"/> <input type="checkbox"/> Emphysema or chronic bronchitis	<input type="checkbox"/> <input type="checkbox"/> Breast problem
<input type="checkbox"/> <input type="checkbox"/> Pneumonia	<input type="checkbox"/> <input type="checkbox"/> Urinary tract infections
<input type="checkbox"/> <input type="checkbox"/> Gastroesophageal reflux disease	<input type="checkbox"/> <input type="checkbox"/> Arthritis
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Thyroid problem
<input type="checkbox"/> <input type="checkbox"/> Osteoporosis/Osteopenia	<input type="checkbox"/> <input type="checkbox"/> Bleeding disorder
<input type="checkbox"/> <input type="checkbox"/> Cancer, Type: _____	<input type="checkbox"/> <input type="checkbox"/> Addiction Issues
<input type="checkbox"/> <input type="checkbox"/> Stomach ulcer	<input type="checkbox"/> <input type="checkbox"/> Depression
<input type="checkbox"/> <input type="checkbox"/> Kidney Disease, Type: _____	<input type="checkbox"/> <input type="checkbox"/> Anxiety
<input type="checkbox"/> <input type="checkbox"/> Liver Disease, Type: _____	<input type="checkbox"/> <input type="checkbox"/> Mental Illness
	<input type="checkbox"/> <input type="checkbox"/> 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		Miscarriages __
<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Legs <input type="checkbox"/> Neck <input type="checkbox"/> Shoulders		Birth control method __
<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: _____