



ADULT HEALTH QUESTIONNAIRE

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____ **TODAY'S DATE:** _____

What would you like to talk to your doctor about today? _____

MEDICAL HISTORY

Please list any medication allergies or reactions:

Please check to indicate if you have ever had the following conditions:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Diabetes (250.00) | <input type="checkbox"/> High blood pressure (401.9) | <input type="checkbox"/> Asthma (493.20) | <input type="checkbox"/> Heart attack (411.89) |
| <input type="checkbox"/> Kidney disease (588.8) | <input type="checkbox"/> Hepatitis (571.40) | <input type="checkbox"/> Thyroid disease (244.9 hypo; 242.9 hyper) | |
| <input type="checkbox"/> Stroke (436) | <input type="checkbox"/> Depression (311) | <input type="checkbox"/> Emphysema (496) | <input type="checkbox"/> Seizures (345.10) |
| <input type="checkbox"/> Tuberculosis (011.90) | <input type="checkbox"/> Coronary Artery Disease (414.00) | <input type="checkbox"/> Congestive Heart Failure (428.00) | |
| <input type="checkbox"/> Arrhythmia (427.9) | <input type="checkbox"/> Sexually transmitted disease – type: _____ | | |
| <input type="checkbox"/> Eye problems – type: _____ | <input type="checkbox"/> Cancer – type: _____ | | |
| <input type="checkbox"/> Other, please explain: _____ | | | |

Please list any surgeries or hospital stays you have had and their approximate date/year:

<i>Type of surgery / reason for hospitalization / location</i>	<i>Date</i>
_____	_____
_____	_____
_____	_____

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

When was your last physical?

Please list all medications, including vitamins, herbal or natural supplements and prescription medications, which you are currently taking. Please note the dosage if possible.

<i>Medication Name</i>	<i>Dosage</i>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What pharmacy do you use for prescription medications?

Are you currently receiving care from any other doctors, chiropractors, or other health care professionals? If yes, we would like to know whom so that we can coordinate your care:

<i>Provider's name</i>	<i>Condition they are treating you for</i>
_____	_____
_____	_____
_____	_____

Please note dates of your most recent immunizations:

	<i>Approximate Date</i>		<i>Approximate Date</i>
Tetanus	_____	Influenza	_____
Pneumonia	_____	Hepatitis B	_____
Other: _____	_____	Other: _____	_____

If you have had any of the following tests done, please note when the tests was done and what the results were, if known:

<i>Test</i>	<i>Approximate Date</i>	<i>Result</i>
Cholesterol	_____	_____
Pap smear/pelvic	_____	_____
Mammogram	_____	_____
Blood in stool	_____	_____
HIV	_____	_____
Colonoscopy	_____	_____
Hepatitis C	_____	_____

FAMILY HISTORY

Check any of the diseases that run in your family **and** please note who had it:

	None	Mother	Father	Sister	Brother	Grandmother (mother's side)	Grandfather (mother's side)	Grandmother (father's side)	Grandfather (father's side)	Child	Other (Please explain)
Alcoholism or Drug Use											
Cancer											
Cancer Type											
Diabetes											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Osteoporosis											
Mental Illness											
Stroke											
Thyroid Disease											
Other											

Other Comments:

HEALTH HABITS

Do you smoke or use any tobacco products?..... Yes No Quit

Number of cigarettes each day? _____

For how many years? _____

Other forms of tobacco used? _____

Do you drink alcohol?..... Yes No Quit

How much? _____

How often? _____

Have you ever felt that you should cut down on your drinking?..... Yes No

Have you regularly used other drugs?..... Yes No

If yes, are you still using them?..... Yes No

PERSONAL HISTORY

- Are you currently married or living with a significant other?..... Yes No
 Who lives with you at home? _____
- Are you employed?..... Yes No
 If yes, what kind of work do you do? _____
 If no, is this by choice? ___ Disability? ___ Other reasons? _____
- Do you exercise more than 2 times per week?..... Yes No
- Do you often feel sad or depressed?..... Yes No
- Do you feel there is something seriously wrong with your body?..... Yes No
- Are you having money problems which limit your access to food, shelter or medical care?..... Yes No
- In the last year, have there been any major changes in your life like marriage, divorce, death of a family member or close friend, illness or injury, or change in job situation?..... Yes No
- Do you have some form of church or spiritual support? Yes No

SEXUAL HISTORY

- Are you sexually active? Yes No
 With: Men Women Both
- Do you feel you are at risk for HIV/AIDS? Yes No
- Do you have children? Yes No
 How many children do you have? _____
- Do you use any form of birth control? Yes No
 If yes, which type / brand? _____

WOMEN ONLY

- Have you ever been pregnant? Yes No
 How many times? _____
 How many miscarriages? _____
 How many abortions? _____
 How many children do you have living? _____
- Do you have menstrual periods? Yes No
 If no, at what age did they stop? _____
 If yes, are your periods regular? _____

OTHER COMMENTS:
