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| HEALTH HISTORY - ADULT | | | | | | | | | | | | | | |
| All questions contained in this questionnaire are strictly confidential  and will become part of your medical record. | | | | | | | | | | | | | | |
| Name (Last, First, M.I.): | | |  | | | | | M  F | | DOB: | |  | | |
| Marital status: | | Single  Partnered  Married  Separated  Divorced  Widowed | | | | | | | | | | | | |
| Referred by: | | | | |  | | Date of last physical exam: | | | | | | |  |
|  | | | | | | | | | | | | | | |
| PERSONAL HEALTH HISTORY | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Childhood illness: | | | 🞎 Measles 🞎 Mumps 🞎 Rubella 🞎 Chickenpox 🞎 Rheumatic Fever 🞎 Polio 🞎 Other | | | | | | | | | | | |
| Immunizations and | | | | Tetanus | |  | Pneumonia | | | |  | | | |
|  | | | | Hepatitis | |  | Chickenpox | | | |  | | | |
|  | | | | Influenza | |  | MMR | | | | | |  | |
| List any medical problems | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | | |
| Surgeries | | | | | | | | | | | | | | |
| Year | Type of surgery | | | | | | | | Recovery time | | | | | |
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| Other hospitalizations | | | | | | | | | | | | | | |
| Year | Reason | | | | | | | | Recovery time | | | | | |
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| List all prescribed drugs and over-the-counter drugs, such as vitamins and supplements | | | | | | | | | | | |
| Name | | | Strength | | | Frequency Taken | | | | | |
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| Allergies to medications | | | | | | | | | | | |
| Name | | | Reaction | | | | | | | | |
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| HEALTH History CONT’D | | | | | | | | | | | |
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|  | | | | | | | | | | | |
| Exercise | Sedentary (No exercise) | | | | | | | | | | |
| Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | | | | | | | | |
| Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | | | | | | | | |
| Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | | | | | | | | |
| Diet | Are you dieting? | | | | | | |  | Yes |  | No |
| If yes, are you on a physician prescribed medical diet? | | | | | | |  | Yes |  | No |
| Favorite foods/cravings? | | | | | | | | | | |
| Rank salt intake | Hi | | Med | Low | | | | | | |
| Rank fat intake | Hi | | Med | Low | | | | | | |
| Caffeine | 🞎 None | Coffee | | Tea | Cola | | | | | | |
| # of cups/cans per day? | | | | | | | | | | |
| Alcohol | Do you drink alcohol? | | | | | | |  | Yes |  | No |
| How many drinks do you have per week? | | | | | | | | | | |
| Are you or have you ever been prone to “binge” drinking? | | | | | | |  | Yes |  | No |
| Tobacco | Do you use tobacco? | | | | | | |  | Yes |  | No |
| Cigarettes – pks./day | | | Chew - #/day | Pipe - #/day | | Cigars - #/day | | | | |
| # of years | Or years quit | | | | | | | | | |
| Drugs | Do you currently use recreational or street drugs? | | | | | | |  | Yes |  | No |

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| FAMILY HEALTH HISTORY | | | | | | | |
|  | | | | | | | |
|  | Age | | Significant Health Problems |  | Age | | Significant Health Problems |
| Father |  | |  | Children | M  F |  |  |
| Mother |  | |  | M  F |  |  |
| Siblings | M  F |  |  | M  F |  |  |
| M  F |  |  | M  F |  |  |
| M  F |  |  | Grandmother Maternal |  | |  |
| M  F |  |  | Grandfather Maternal |  | |  |
| M  F |  |  | Grandmother Paternal |  | |  |
| M  F |  |  | Grandfather Paternal |  | |  |

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| MENTAL HEALTH | | | | |
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| Is stress a major problem for you? |  | Yes |  | No |
| Do you feel depressed? |  | Yes |  | No |
| Do you have panic or anxiety attacks? |  | Yes |  | No |
| Do you have problems with eating or your appetite? |  | Yes |  | No |
| Do you cry frequently/easily? |  | Yes |  | No |
| Have you ever attempted suicide? |  | Yes |  | No |
| Do you have trouble sleeping? |  | Yes |  | No |
| Do you have recurring dreams? |  | Yes |  | No |

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| WOMEN ONLY | | | | |
|  | | | | |
| Age at onset of menstruation: | | | | |
| Date of last menstruation: | | | | |
| Period every       days | | | | |
| Heavy periods, irregularity, spotting, pain, or discharge? |  | Yes |  | No |
| Number of pregnancies       Number of live births | | | | |
| Are you pregnant or breastfeeding? |  | Yes |  | No |
| Have you had a D&C, hysterectomy, or Cesarean? |  | Yes |  | No |
| Any urinary tract, bladder, or kidney infections within the last year? |  | Yes |  | No |
| Any blood in your urine? |  | Yes |  | No |
| Any problems with control of urination? |  | Yes |  | No |
| Any hot flashes or sweating at night? |  | Yes |  | No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? |  | Yes |  | No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? |  | Yes |  | No |
| Date of last pap and rectal exam? | | | | |
|  | | | | |
| MEN ONLY | | | | |
|  | | | | |
| Do you usually get up to urinate during the night? |  | Yes |  | No |
| If yes, # of times | | | | |
| Do you feel pain or burning with urination? |  | Yes |  | No |
| Any blood in your urine? |  | Yes |  | No |
| Has the force of your urination decreased? |  | Yes |  | No |
| Have you had any kidney, bladder, or prostate infections within the last 12 months? |  | Yes |  | No |
| Do you have any problems emptying your bladder completely? |  | Yes |  | No |
| Any difficulty with erection or ejaculation? |  | Yes |  | No |
| Any testicle pain or swelling? |  | Yes |  | No |
|  | | | | |
| OTHER | | | | |
|  | | | | |
| Check if you have, or have had, any symptoms in the following areas to a significant degree and explain. | | | | |

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| --- | --- | --- | --- | --- | --- |
|  | Skin |  | Chest/Heart |  | Recent changes in: |
|  | Head/Neck |  | Back |  | Weight |
|  | Ears |  | Intestinal |  | Energy level |
|  | Nose |  | Bladder |  | Ability to sleep |
|  | Throat |  | Bowel |  | Other pain/discomfort: |
|  | Lungs |  | Circulation |  |  |