Carpenter Primary Healthcare

Initial Adult History Questionnaire

Today's Date: _____ Patient Name: _____ DOB: _____

How did you hear about our office? _____

Please list any specialists you are currently seeing: _____

_____

Reason for today's visit: _____

Do you have a medical advance directive or a living will? ☐ Yes ☐ No (If yes, please provide our office with a copy.)

Do you need any of the following: (Please circle)

Disability Paperwork · Return to work note Surgical Clearance Prescription Refills Beside Commode Rolling Walker Cane

Are you interested in any of the following? (Please Circle)

Weight Loss HIV screening Diabetes screening Preventing pregnancy STD screening Cervical Cancer Vaccine Shingles Vaccine

Past Medical History

Abnormal Heart Rhythm	☐ Currently ☐ Past	Joint Pain (specify)_____	☐ Currently ☐ Past
Asthma	☐ Currently ☐ Past	Kidney Disease	☐ Currently ☐ Past
Back Pain	☐ Currently ☐ Past	Liver Disease	☐ Currently ☐ Past
Bipolar Disorder	☐ Currently ☐ Past	Lupus	☐ Currently ☐ Past
Cancer Specify: _____	☐ Currently ☐ Past	Neuropathy	☐ Currently ☐ Past
Congestive Heart Failure	☐ Currently ☐ Past	Sarcoidosis	☐ Currently ☐ Past
Depression	☐ Currently ☐ Past	Stomach Ulcers	☐ Currently ☐ Past
Diabetes	☐ Currently ☐ Past	Stroke	☐ Currently ☐ Past
Emphysema	☐ Currently ☐ Past	Other: _____	☐ Currently ☐ Past
Fibromyalgia	☐ Currently ☐ Past	Other: _____	☐ Currently ☐ Past
Heart Attack or blockages	☐ Currently ☐ Past		
High Blood Pressure	☐ Currently ☐ Past		
High Cholestrol	☐ Currently ☐ Past		
HIV	☐ Currently ☐ Past		

Family History

Please use the following key: MGM- Maternal Grandmother, PGM- Paternal Grandmother, MGF- Maternal Grandfather, PGF- Paternal Grandfather, M-Mother, F-Father, A- Aunt , U- Uncle, B-Brother, S- Sister, C- Cousin

Heart attack	☐ Yes ☐ No	Who _____	Comments _____
Congestive Heart Failure	☐ Yes ☐ No	Who _____	Comments _____
Diabetes	☐ Yes ☐ No	Who _____	Comments _____
Dialysis for Kidney Disease	☐ Yes ☐ No	Who _____	Comments _____
Cancer, (Type): _____	☐ Yes ☐ No	Who _____	Comments _____
Hypertension	☐ Yes ☐ No	Who _____	Comments _____

Additional Family History: _____

_____

Social History

What is your occupation? _____

Do you have a significant other? ☐ Yes ☐ No Marital Status: _____

Do you have any children? ☐ Yes ☐ No If yes, how many? _____

Have you ever used tobacco? ☐ Currently ☐ Formerly ☐ Occasionally ☐ Never

If yes: Packs per day_____ How many years?_____

Do you drink alcohol? ☐ Currently ☐ Formerly ☐ Occasionally ☐ Never

If yes, what do you drink? _____ How much? _____ How often? _____

Have you ever done drugs? ☐ Currently ☐ Formerly ☐ Occasionally ☐ Never

If yes, please specify drug and length of use: _____

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Reproductive History (Women Only)

Do you have regular monthly periods? ☐ Yes ☐ No

Number of days in cycle? _____

Heavy Bleeding? ☐ Yes ☐ No Painful? ☐ Yes ☐ No

What age did you start having periods?

What age did you stop having periods? _____ Reason: _____

Have you ever been pregnant? ☐ Yes ☐ No Number of pregnancies? _____ Complications? _____

Past Surgical History

Please check any surgeries you have had:

☐ Amputation , Please specify: _____ Date: _____

☐ Appendix Removed Date: _____

☐ Back Surgery Please specify: _____ Date: _____

☐ Gallbladder Removed Date: _____

☐ Heart Bypass/ Stent Date: _____

☐ Hysterectomy - ☐ Partial or ☐ Total Reason? _____ Date: _____

☐ Mastectomy Date: _____

☐ Tonsillectomy Date: _____

Please list and other surgeries with details:

_____

_____

_____

Medication

Name of Medication	Dose	Number of times per day	Name of Medication	Dose	Number of times per day

Medication Allergies- Please list name of medication and type of reaction: _____

_____

Other Allergies- Please list name and type of reaction: _____

Preventative Care

Name of test	Date done	Results	Ordering Doctor
Pap Smear			
Mammogram			
Prostate Blood Test			
Stool Cards			
Colonoscopy			
Pneumonia Vaccine			
Tetanus Vaccine			