Adult Health History Questionnaire

Name: _____ Date of birth: ____ / ____ / _____

Address: _____

Landline phone: (____) ____-_____ Cell phone: (____) ____-_____ Work phone: (____) ____-_____

Email address: _____

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

☐To establish primary care ☐Current concern(s): _____

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

Check if you have had any of the following:

☐Acute myocardial infarction	☐Hepatic disorders
☐Atrial fibrillation	☐Renal disease
☐Angina pectoris	☐Prostate disorders
☐Congestive heart failure	☐Urinary tract infection
`☐Hyperlipidemia	☐Arthritis
☐Hypertension	☐Neuropathy
☐Cardiac rhythm disorder	☐Epilepsy and recurrent seizures
☐Asthma	☐Headache syndromes
☐Chronic bronchitis	☐Stroke syndrome
☐Emphysema	☐Aneurysm
☐Pneumonia	☐Coagulation disorders
☐Gastroesophageal reflux disease (GERD	☐Cancer (please specify location)
☐Irritable bowel syndrome (IBS)	☐Breast disorder
☐Disease of digestive system	☐Anxiety disorder
☐Peptic ulcer	☐Depressive episode
☐Diabetes mellitus	☐Unspecified mental
☐Osteopenia	disorder non-psychotic
☐Osteoporosis	☐Substance abuse
☐Thyroid disorders	☐Other diagnoses & conditions

Previous Surgical Procedures

Check if you have had any of the following:

Procedure	Year
☐Heart surgery	
☐Pacemaker	
☐Carotid artery surgery	
☐Vascular surgery / stent	
☐Abdominal aneurysm repair	
☐Hysterectomy ☐Abdominal ☐Vaginal	
☐Ovary removal ☐Right ☐Left ☐Bilateral	
☐Gall bladder removal	
☐Appendix removal	
☐Total Colectomy	
☐Tonsillectomy	
☐Joint replacement ☐Knee ☐Right ☐Left ☐Hip ☐Right ☐Left	
☐Spine surgery ☐Neck ☐Back	
☐Mastectomy ☐Right ☐Left ☐Bilateral	
☐Breast lumpectomy	
☐Hernia	
☐Prostate cancer surgery	
☐Other	

Social History

Marital status: ☐Single ☐ Married ☐ Divorced ☐Widowed ☐Life Partner

Live here year-round? ☐ Yes ☐ No If no, provide seasonal address:

Occupation: _____ ☐Full time ☐Part time ☐Retired

Concerns: ☐Stress ☐Hazardous substances ☐Heavy lifting ☐Other: _____

Exercise: ☐Yes ☐No If yes, how many minutes per day? _____ How many days per week? _____

Tobacco use: ☐Never ☐ Quit (when? _____) ☐ Current smoker (packs per day? _____ number of years? _____

Alcohol use: ☐Yes ☐No If yes, how many per: day _____ week _____ ☐Social drinker

Caffeine use: ☐Yes ☐No If yes, how many cups per day? _____

Illicit drug use (including cocaine, steroids, etc.): ☐Never ☐Past ☐Current ☐Marijuana by prescription

Describe drug, frequency, purpose:

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing:

☐Chest pain/discomfort	☐Rectal bleeding	☐Eye pain	☐Pain in testicles
☐Shortness of breath	☐Black/tarry stools	☐Loss of vision	☐Loss of libido
☐Wheezing	☐Hemorrhoids	☐Double vision	☐Impotence
☐Cough	☐Diarrhea	☐Memory lapses/loss	☐Breast pain
☐Coughing up blood	☐Constipation	(forgetfulness)	☐Breast discharge
☐Sore throat	☐Weight loss (____ lbs)	☐Ringing in ears	☐Other (describe below)
☐Nasal congestion	☐Weight gain (____ lbs)	☐Pain in ears	
☐Irregular heartbeat	☐Loss of appetite	☐Nose bleeds	
☐Fast heartbeat	☐Difficulty swallowing	☐Hoarseness	
☐High blood pressure	☐Painful urination	☐Easy bleeding	
☐Low blood pressure	☐Blood in urine	☐Easy bruising	Females - Please complete
☐Lightheadedness	☐Frequent urination	☐Rash	Menstrual flow:
☐Dizziness/fainting	☐Decrease in urine flow	☐Changes in a mole	Reg Irreg Pain/cramps
☐Heartburn	☐Headaches, frequent	☐Sore that won't heal	Days of flow: _____
☐Indigestion	☐Loss of strength	☐Insomnia	Pain or bleeding after sex
☐Ankle/foot swelling	☐Balance problems	☐Depression	Number of pregnancies: ___
☐Nausea	☐Pain, weakness or numbness in:	☐Nervousness	Number of miscarriages: ___
☐Vomiting	☐Arms ☐Hips ☐ Low back		Birth control method: _____
☐Vomiting blood	☐Legs ☐Neck ☐ Shoulders		Menopause:
☐Change in bowel habits	☐Hands ☐Feet ☐ Abdomen		Yes No Age:

Family History

Father ☐Living ☐Deceased at age _____

Brother ☐Living ☐Deceased at age _____

Brother ☐Living ☐Deceased at age _____

Brother ☐Living ☐Deceased at age _____

Mother ☐Living ☐Deceased at age _____

Sister ☐Living ☐Deceased at age _____

Sister ☐Living ☐Deceased at age _____

Sister ☐Living ☐Deceased at age _____

☐Adopted/Family health history unobtainable

Please check all that apply

	Father	Mother	Brother(s)	Sister(s)
Denies significant symptoms				
Alcoholism				
Allergies				
Alzheimer's				
Aneurysm				
Anxiety disorder				
Arthritis				
Asthma				
Bleeding problems				
Cancer (list type)				
Drug dependence				
Depression				
Diabetes				
GI disorders				
Glaucoma				
Heart attack				
Heart disease				
HIV				
High cholesterol				
Hypertension				
Kidney disease				
Liver disease				
Lung disease				
Mental/Psychiatric disorder				
Migraines				
Neurological disorder				
Neuropathy				
Seizure disorder				
Stroke				
Thyroid disorder				
Other				

Are there any religious or cultural factors that you would like us to consider when planning your health care?

Health Maintenance

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

Immunizations	Last Occurrence Month/Year
Tetanus vaccine / Tdap	
Pneumonia vaccine ☐Pneumovax 23 ☐Prevnar 13 ☐Vaxneuvance ☐Prevnar 20	
Influenza vaccine	
Shingles vaccine ☐Zostavax ☐Shingrix	
Hepatitis A	
Hepatitis B	
Gardasil (HPV)	

Tests	Last Occurrence Month/Year
Breast cancer screening ☐Mammogram bilateral ☐Left breast ☐Right breast	
Cervical cancer screening ☐Pelvic exam ☐Pap smear ☐Positive ☐Negative	
Human papilloma virus screening Positive Negative	
Colorectal cancer screening ☐Colonoscopy (next due in ___ years) ☐FOBT (stool lab test) ☐Positive ☐Negative ☐Flexible sigmoidoscopy ☐Cologuard	
Chest x-ray	
Prostate-specific antigen (PSA)	
Bone density	
Low-dose CT lung	

Allergies

Please list any allergies to medications or foods and give the reaction you experience if eaten/taken.

Name of food / drug	Symptom / Reaction

Surgical and Hospitalization History		
Please list all surgeries. Also list any non-surgical hospitalizations in the past 12 months.		
Hospital / Surgeon	Date	Reason for admission/surgery

Medications		
Please list any medications you take, including over-the-counter meds, herbs, and supplements		
Name	Dose	Frequency

Care Team
So we can best coordinate your care, please list any medical providers you see outside this practice
Allergist Practice *AND* name of doctor: _____ Phone: _____ Last seen: _____
Cardiologist Practice *AND* name of doctor: _____ Phone: _____ Last seen: _____
Dentist / Oral Surgeon Practice *AND* name of doctor: _____ Phone: _____ Last seen: _____
Endicrinologist Practice *AND* name of doctor: _____ Phone: _____ Last seen: _____
Gastroenterologist Practice *AND* name of doctor: _____ Phone: _____ Last seen: _____
Gynecologist (OB/GYN) Practice *AND* name of doctor: _____ Phone: _____ Last seen: _____
Nephrologist Practice *AND* name of doctor: _____ Phone: _____ Last seen: _____
Oncologist Practice *AND* name of doctor: _____ Phone: _____ Last seen: _____
Opthamologist Practice *AND* name of doctor: _____ Phone: _____ Last seen: _____
Orthopedist Practice *AND* name of doctor: _____ Phone: _____ Last seen: _____
Podiatrist Practice *AND* name of doctor: _____ Phone: _____ Last seen: _____
Psychiatrist / Psychologist Practice *AND* name of doctor: _____ Phone: _____ Last seen: _____
Pulmonologist Practice *AND* name of doctor: _____ Phone: _____ Last seen: _____
Urologist Practice *AND* name of doctor: _____ Phone: _____ Last seen: _____
Other Practice *AND* name of doctor: _____ Phone: _____ Last seen: _____