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:

- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Arrhythmia
- ☐ Eye Problems
- ☐ High Blood Pressure
- ☐ Hepatitis
- ☐ Coronary Artery Disease
- ☐ Sexually Transmitted Disease
- ☐ Asthma
- ☐ Thyroid Disease
- ☐ Emphysema
- ☐ Congestive Heart Failure
- ☐ Cancer
- ☐ Heart Attack
- ☐ Seizures
- ☐ Other (please explain) :

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

Type of surgery/ Reason for hospitalization /Location — Date

______________________________ ____________
______________________________ ____________
______________________________ ____________

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 dosage if possible.

Medication Name: — Dosage:

______________________________ ____________
______________________________ ____________
______________________________ ____________
______________________________ ____________

What pharmacy do you use for prescription medications?

____

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

Provider's Name: — Condition they are treating for:

______________________________ ____________
______________________________ ____________

Please Note dates of your most recent immunizations:

	Approximate Date:		Approximate Date:
Tetanus	____________	Influenza	____________
Pneumonia	____________	Hepatitis B	____________
Other:____________________________		____________________________________	

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

Test	**Approximate Date:**	**Results:**
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:

☐ Alcoholism or drug use	____________________________
☐ Cancer	____________________________
☐ Diabetes	____________________________
☐ Heart Disease	____________________________
☐ High Blood Pressure	____________________________
☐ High Cholesterol	____________________________
☐ Osteoporosis	____________________________
☐ Mental Illness	____________________________
☐ Stroke	____________________________
☐ Thyroid Disease	____________________________
☐ Other	____________________________

Other comments:

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____

Health Habits

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

Number of cigarettes a 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 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

Are you employed? ____ Yes ____ No

If yes, what kind of work do you do? _________________________________

If no, is this by choice? __________ Disability? __________ Other? _________________

Do you exercise more than 2 times a week? ____ Yes ____ No

Do you often feel 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 any children? ______ Yes ______ No

How many children do you have? ________

Do you use any form of birth control? ______ Yes ______ No

If yes, which form? ____

Women Only

Have you ever been pregnant? _____ Yes _____ No

How many times? _______________

How many miscarriages? _____________

How many abortions? _______________

Do you have menstrual periods? _____ Yes _____ No

If no, at what age did they stop? _____________

If yes, are your periods regular? _____________

Other Comments

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