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, please leave them blank. Thank you for your help.

PATIENT NAME: ______________________________ PATIENT DOB: ________________ TODAY'S DATE: ____________

BRIEFLY, WHAT IS YOUR REASON FOR TODAY'S VISIT?: ____

PLEASE LIST ANY MEDICATION ALLERGIES AND/OR REACTIONS: ____

PLEASE CHECK TO INDICATE IF YOU HAVE EVER HAD THE FOLLOWING CONDITIONS:

☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ ASTHMA ☐ STROKE
☐ KIDNEY DISEASE ☐ HEART ATTACK ☐ HEPATITIS ☐ DEPRESSION
☐ ANEMIA ☐ ANGINA ☐ ANXIETY ☐ GERD
☐ THYROID DISEASE ☐ EMPHYSEMA ☐ SEIZURES ☐ ARRYTHMIA
☐ TUBERCULOSIS ☐ CORONARY ARTERY DISEASE ☐ CONGESTED HEART FAILURE
☐ EYE PROBLEMS ☐ CANCER – TYPE: ____________ ☐ HIGH CHOLESTEROL
☐ OTHER(s): ____

PLEASE INDICATE ANY SURGERIES YOU HAVE HAD:

☐ ANGIOPLASTY ☐ ANGIOPLASTY W/ STENT ☐ APPENDECTOMY ☐ COLECTOMY
☐ ARTHROSCOPY KNEE (L,R,B) ☐ BACK/NECK SURGERY ☐ CORONARY BYPASS/ CABG ☐ COLOSTOMY
☐ CARPAL TUNNEL RELEASE (L,R,B) ☐ CATARACT EXTRACTION ☐ CHOLECYSTECTOMY ☐ GASTRIC BYPASS
☐ HERNIA REPAIR ☐ HIP REPLACEMENT (L,R,B) ☐ LASIK ☐ LIVER BIOPSY
☐ ORIF/FRACTURE REPAIR ☐ PACEMAKER PLACEMENT ☐ THYROIDECTOMY ☐ TONSILLECTOMY
☐ PROSTATE BIOPSY ☐ TURP/ PROSTATE RESECTION ☐ VASECTOMY ☐ HYSTERECTOMY (FULL/PARTIAL)

OTHER SURGICAL PROCEDURES: ____

PLEASE CHECK ANY OF THE FOLLOWING SCREENING TESTS YOU HAVE HAD *__INCLUDING THE APPROX. DATE OF SERVICE__*, AND INDICATE THE PLACE OF SERVICE OR PROVIDER/PROVIDER'S OFFICE WHERE RECORDS CAN BE OBTAINED:

☐ WELLNESS VISIT: ______________________ ☐ FOBT: ______________________
☐ COLONOSCOPY: ______________________ ☐ EYE EXAM: ______________________
☐ FOOT EXAM: ______________________ ☐ MAMMOGRAM: ______________________
☐ BONE DENSITY (DEXA): ______________________ ☐ PAP SMEAR: ______________________
☐ PSA: ______________________

IMMUNIZATIONS YOU RECEIVE, AND APPROX DATE LAST RECEIVED:

☐ PNEUMOCOCCAL: ______________________ ☐ PREVNAR 13: ______________________
☐ ZOSTER: ______________________ ☐ FLU: ______________________
☐ TETANUS: ______________________ ☐ "I REFUSE VACCINATIONS/IMMUNIZATIONS"

PLEASE INDICATE YOUR HABITS: (check, and circle accordingly where noted)

☐ CIGARETTES/CIGARS → AGE STARTED & STOPPED: ____/____ HOW MANY PACKS/CIGS/CIGARS PER DAY? _________
☐ ALCOHOL → BEER/WINE/LIQUOR HOW MANY: _______PER DAY/WEEK/MONTH/YEAR
☐ CAFFEINE → SODA/TEA/COFFEE/CHOCOLATE HOW MANY CUPS ON AVERAGE PER DAY? _________

FAMILY HISTORY (IF DECEASED, PLEASE INDICATE AGE): *PLACE FAMILY MEMBER LETTER NEAR EACH CONDITION*

(M) MOTHER ____ (F) FATHER ____ (B) BROTHER ____ (S) SISTER ____

☐ HYPERTENSION ☐ HEART ATTACK ☐ BLOOD PROBLEMS ☐ LUNG PROBLEMS ☐ BREAST CANCER
☐ KIDNEY PROBLEMS ☐ LIVER PROBLEMS ☐ COLON CANCER ☐ STOMACH CANCER ☐ LUNG CANCER
☐ GLAUCOMA ☐ STROKE ☐ DIABETES ☐ OTHER ______________________