

Adult Health History Questionnaire

New Patients: Please fill out to the best of your ability.

Established Patients: Please help us update our records since your last annual exam.

Current health concerns: _____

Health System Review

Check if you have any symptoms or problems.

General

- unexplained weight loss or gain _____ pounds
- fevers/night sweats
- fatigue
- daytime sleepiness
- swollen or enlarged lymph glands

Eyes/Ears/Nose/Throat

- recent change in vision
- date of last eye exam ___/___/___
- hearing loss
- vertigo or dizziness

Abdomen

- swallowing difficulty
- heartburn/indigestion
- abdominal pain
- vomiting blood
- black or bloody bowel movements
- change in bowel habits

Emotional Health

- anxiety, nervousness
- persistent sadness, crying spells
- feeling hopeless
- thoughts of death
- irritability
- sleep problem
- excessive worrying
- trouble getting along with people
- victim of abuse (physical, financial, sexual)

Skin/Glands

- change in mole or skin lesion of concern
- increased thirst or urination

Heart/Lungs

- chest pain with activity
- palpitations
- fainting
- leg pain with exertion
- leg swelling
- persistent cough
- shortness of breath/wheezing

Urinary/Genital/Breast

- urine leakage
- difficulty urinating
- sexual difficulty
- sexually transmitted disease exposure
- menstrual concern
- vaginal discharge, odor, itching
- penile discharge
- breast lump or nipple discharge
- testicular lump or swelling

Muscles/Neurologic

- numbness or tingling
- balance or walking problems
- falls
- headaches
- memory difficulties
- muscle pain / muscle weakness

Please Turn Over to Complete other Side



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Patient Name:

DOB:

MRN:

Clinic Location:

List all prescription medications, over the counter medications, vitamins/supplements you are currently taking, include dosage:

Reactions or allergies to medications:

Specific medical events and chronic problems (Hospitalizations, asthma, hypertension, etc.):

Operations (gall bladder, appendix, etc.):

Vaccinations:

- Tetanus
- Pneumonia
- Hepatitis A
- Hepatitis B

Year given

- Meningococcal
- Shingles
- HPV

(cervical cancer)

Year given

Habits:

Alcohol: none drinks/day _____ drinks/week _____ Type: wine beer hard liquor
Cigarettes/tobacco: no yes # of packs/day _____ quit date: _____
Caffeine: none coffee tea other # of 8oz. cups/day: _____
Other drugs (marijuana, cocaine...): _____

Nutrition: Is there anything I should know about your eating habits? _____

Exercise: Type _____ Minutes/day: _____ days/week: _____

Occupation: _____ Safety: Y / N seat belts Y / N smoke detectors

Relationship status: Single Married Divorced Separated Widowed
 Lesbian/Gay Bisexual Long-term relationship Partner/spouse

Family History: of cancer, diabetes, early heart disease, blood problems, other hereditary problems.

For Provider Only

Questions above and positive responses were reviewed by me. See note for details and discussions.

Provider Signature: _____

Date: _____