

ADULT HEALTH QUESTIONNAIRE

Date: _____ Please complete this form to better acquaint the physician with your medical history.

Name: _____ Birthdate: _____

Home phone: _____ Daytime phone: _____ SS# _____

Occupation: _____ Marital Status: _____

List any MEDICATION you use regularly, prescription or over the counter, and dose:

List any ALLERGIES OR INTOLERANCES to medication:

List past HOSPITALIZATIONS, SURGERIES, OR MEDICAL CONDITIONS:

Type of Medical Condition or Surgery	Month/Year	Name of Hospital or Doctor

Have YOU ever had the following diseases or conditions?

Seizure Disorder	Yes	No	Anxiety/Depression	Yes	No
Heart Disease/Heart Attack	Yes	No	Liver Disease or Hepatitis	Yes	No
High Blood Pressure	Yes	No	Ulcer	Yes	No
Stroke	Yes	No	Colon Disease	Yes	No
High Cholesterol	Yes	No	Thyroid Disorder	Yes	No
Heart Murmur	Yes	No	Diabetes	Yes	No
Rheumatic Fever	Yes	No	Cancer	Yes	No
Asthma	Yes	No	Kidney or Bladder Disorder	Yes	No
Tuberculosis	Yes	No	Blood Clot	Yes	No
Allergies (environmental)	Yes	No	Sexually Transmitted Infection	Yes	No
Anemia	Yes	No	Arthritis/Gout	Yes	No
Glaucoma	Yes	No			

CIRCLE

1. Have you had your CHOLESTEROL checked in the last 5 years? Yes No
 If so, what were the levels? _____
2. Do you smoke or chew TOBACCO? Yes No
 If so, how much? _____
3. Do you EXERCISE on a regular basis? Yes No
 Type of exercise _____ Frequency _____
4. Do you drink ALCOHOL? If so, how much? _____ Yes No
5. List dates for the following:
 Last tetanus booster? _____
 Last flu shot? _____
 Last pneumonia shot? (if applicable) _____
 Last Hepatitis A shot or series? _____
 Hepatitis B series completed? (series of three) _____

WOMEN ONLY: Last mammogram? _____
 Last pap smear? _____
 If over age 50, last colon exam? _____
 Does your diet contain calcium? _____

MEN ONLY: Last prostate exam? _____
 If over age 50, last colon exam? _____

ALL PATIENTS:

Has a BLOOD RELATIVE ever had the following diseases or conditions?

	Yes	No	Which Relative?
Heart Attack	<input type="radio"/>	<input type="radio"/>	
Arthritis	<input type="radio"/>	<input type="radio"/>	
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	
Stroke	<input type="radio"/>	<input type="radio"/>	
Depression/Anxiety	<input type="radio"/>	<input type="radio"/>	
High Cholesterol	<input type="radio"/>	<input type="radio"/>	
Asthma/Allergies	<input type="radio"/>	<input type="radio"/>	
Thyroid Disease	<input type="radio"/>	<input type="radio"/>	
Osteoporosis	<input type="radio"/>	<input type="radio"/>	
Cancer	<input type="radio"/>	<input type="radio"/>	
Type? _____			
Type? _____			
Depression/Anxiety	<input type="radio"/>	<input type="radio"/>	
Colon Disease	<input type="radio"/>	<input type="radio"/>	
Other:			
