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 DOB: _____ **TODAY'S DATE:** _____

MEDICAL HISTORY:

PLEASE LIST ANY MEDICATIONS ALLERGIES 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 – TYPE: _____ ☐ CANCER – TYPE: _____

☐ OTHER: _____

PLEASE INDICATE ANY SURGERIES YOU HAVE HAD:

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

OTHER SURGICAL PROCEDURES: _____

PLEASE CHECK ANY OF THE FOLLOWING SCREENING TESTS YOU HAVE HAD 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:

☐ PNEUMOCOCCAL: _____ ☐ PREVNAR 13: _____

☐ ZOSTER: _____ ☐ FLU: _____

☐ TETANUS: _____

PLEASE INDICATE YOUR HABITS:

☐ CIGARETTES AGE STARTED: _____ HOW MANY PACKS PER DAY? _____

☐ ALCOHOL HOW MUCH: _____

☐ CAFFEINE SODA/TEA/COFFEE/CHOCOLATE HOW MANY GLASSES PER DAY? _____

FAMILY HISTORY: (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		