



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, ARRHYTHMIA, 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 \_\_\_\_\_