ADULT HEALTH QUESTIONNAIRE

NAME: _____ AGE: _____ DATE: _____

HISTORY OF PAST ILLNESSES/INJURIES:	YES	NO
HIGH BLOOD PRESSURE	❒	❒
COPD/EMPHYSEMA	❒	❒
DIABETES	❒	❒
CANCER	❒	❒
STROKE	❒	❒
HEART DISEASE/RHEUMATIC FEVER	❒	❒
CONGENITAL ABNORMALITIES	❒	❒
SEXUALLY TRANSMITTED DISEASES	❒	❒
CHICKEN POX	❒	❒
OTHER SERIOUS DISEASES	❒	❒
LIST	❒	❒

	YES	NO
HAVE YOU EVER BEEN HOSPITALIZED OR BEEN UNDER MEDICAL CARE FOR VERY LONG?	❒	❒
IF YES, FOR WHAT REASON?		
HAVE YOU HAD ANY HEAD INJURIES?	❒	❒
HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS?	❒	❒

OPERATIONS:

HAVE YOU HAD ANY SURGERY?	❒	❒

LIST: _____

_____

FAMILY HISTORY	IF LIVING:		IF DECEASED:			HAS ANY BLOOD RELATIVE EVER HAD?	YES	NO
	AGE	HEALTH	AGE	CAUSE				
FATHER						CANCER	❒	❒
MOTHER						TUBERCULOSIS	❒	❒
SIBLINGS						DIABETES	❒	❒
						HEART TROUBLE	❒	❒
						HIGH BLOOD PRESSURE	❒	❒
						STROKE	❒	❒
SPOUSE						CONVULSIONS	❒	❒
CHILDREN						SUICIDE OR SEVERE DEPRESSION	❒	❒
						MENTAL ILLNESS	❒	❒
						BLEEDING TENDENCY	❒	❒
						GOUT OR ARTHRITIS	❒	❒
						ALCOHOL OR DRUG PROBLEMS	❒	❒

SOCIAL HISTORY: ❒ SINGLE ❒ MARRIED ❒ SEPARATED ❒ DIVORCED ❒ WIDOWED

	YES	NO
DO YOU LIVE ALONE?	❒	❒
DO YOU EXERCISE?	❒	❒
DO YOU SMOKE?	❒	❒
HOW MUCH? _____		
HAVE YOU EVER SMOKED?	❒	❒
HAVE YOU EVER FELT YOU SHOULD CUT DOWN YOUR DRINKING?	❒	❒

ARE YOU EMPLOYED?

❒ FULL TIME ❒ PART TIME ❒ UNEMPLOYED

WHAT IS YOUR JOB? _____

EDUCATION COMPLETED? _____

SYSTEMIC REVIEW (DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?):

GENERAL:	YES	NO
RECENT WEIGHT CHANGE	❒	❒

SKIN:	YES	NO
JAUNDICE?	❒	❒
HIVES, ECZEMA, OR RASH?	❒	❒
FREQUENT INFECTION?	❒	❒
ABNORMAL PIGMENTATION	❒	❒

HEAD-EARS-NOSE-THROAT:	YES	NO
EYE DISEASE OR INJURY	❒	❒
DO YOU WEAR GLASSES?	❒	❒
DOUBLE OR BLURRED VISION	❒	❒
HEADACHES	❒	❒
GLAUCOMA	❒	❒

HEAD-EARS-NOSE-THROAT:	YES	NO
SNEEZING OR RUNNY NOSE	❒	❒
NOSEBLEEDS	❒	❒
CHRONIC SINUS TROUBLE	❒	❒
EAR DISEASE	❒	❒
IMPAIRED HEARING	❒	❒
ITCHING EYES OR THROAT	❒	❒
DIZZINESS	❒	❒

NECK:	YES	NO
STIFFNESS	❒	❒
THYROID TROUBLE	❒	❒
ENLARGED GLANDS	❒	❒

NAME: _____ DATE: _____

SYSTEMIC REVIEW:

RESPIRATORY:	YES	NO
SPITTING UP BLOOD?	❒	❒
CHRONIC COUGH	❒	❒
ASTHMA/WHEEZING	❒	❒
PNEUMONIA/PLEURISY	❒	❒
TUBERCULOSIS OR POSITIVE TB TEST	❒	❒

CARDIOVASCULAR:	YES	NO
CHEST PAIN/ANGINA/HEART ATTACK	❒	❒
SHORTNESS OF BREATH WHILE WALKING	❒	❒
HIGH BLOOD PRESSURE	❒	❒
SWELLING OF HANDS, FEET, ANKLES	❒	❒
AWAKENING IN THE NIGHT GASPING	❒	❒
HEART MURMUR/PALPITATIONS	❒	❒
VARICOSE VEINS	❒	❒

GASTROINTESTINAL:	YES	NO
PEPTIC ULCER (STOMACH/DUODENAL)	❒	❒
HEARTBURN/INDIGESTION	❒	❒
VOMITING FOOD OR BLOOD	❒	❒
GALLBLADDER DISEASE	❒	❒
LIVER TROUBLE/HEPATITIS	❒	❒
PAINFUL/BLOODY BOWEL MOVEMENTS	❒	❒
HEMORRHOIDS/PILES OR BLACK STOOLS	❒	❒
CHANGE IN BOWEL MOVEMENTS	❒	❒
CRAMPING OR PAIN IN ABDOMEN	❒	❒
DOES FOOD STICK IN THROAT?	❒	❒

GYNECOLOGICAL (FEMALES ONLY):

AGE PERIODS STARTED _____

HOW LONG PERIODS LAST_____

FREQUENCY OF PERIODS_____

NUMBER OF PREGNANCIES_____

NUMBER MISCARRIAGES/ABORTIONS_____

DATE OF LAST PAP SMEAR_____

DATE OF LAST MAMMOGRAM_____

CONTRACEPTION _____

GENITOURINARY:	YES	NO
LOSS OF URINE	❒	❒
FREQUENT URINATION (DAY OR NIGHT)	❒	❒
BURNING OR PAINFUL URINATION	❒	❒
BLOOD IN URINE	❒	❒
KIDNEY TROUBLE (STONES, ETC.)	❒	❒

LOCOMOTOR-MUSCULOSKELETAL:	YES	NO
ARTHRITIS	❒	❒
ANY DIFFICULTY IN WALKING	❒	❒
ANY PAIN IN CALVES OR BUTTOCKS WHEN WALKING,	❒	❒
RELIEVED BY REST	❒	❒
BACK INJURY	❒	❒

NEUROLOGIC:	YES	NO
HAVE YOU HAD FAINTING SPELLS?	❒	❒
CONVULSIONS/SEIZURES	❒	❒
PARALYSIS	❒	❒
MUSCLE WEAKNESS	❒	❒

ENDOCRINE:	YES	NO
THYROID DISEASE	❒	❒
HORMONE THERAPY	❒	❒
ANY CHANGE IN HAIR GROWTH	❒	❒
HAVE YOU BECOME COLDER THAN BEFORE,	❒	❒
OR HAS SKIN BECOME DRYER?	❒	❒

PSYCHIATRY:	YES	NO
HAVE YOU EVER BEEN ADVISED TO SEEK OR HAVE	❒	❒
YOU SOUGHT TREATMENT FOR:	❒	❒
DEPRESSION	❒	❒
ANXIETY AND/OR PANIC	❒	❒
SEVERE STRESS	❒	❒
ALCOHOL AND/OR DRUG ABUSE	❒	❒
WORK OR FAMILY PROBLEMS	❒	❒

MALE GENITOURINARY:	YES	NO
PROSTATE TROUBLE	❒	❒
PAINFUL TESTICLES	❒	❒
WEAK URINE STREAM	❒	❒

PLEASE LIST ALL KNOWN ALLERGIES (DRUGS, FOOD, ANIMALS, ETC.):

_____

_____

WHAT IS THE PRIMARY REASON YOU CAME TO SEE THE DOCTOR TODAY?

_____

_____

_____

SIGNATURE OF PATIENT: _____ DATE: _____