# 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:**

| | Year given | | Year given |
|---|---|---|---|
| ❑ Tetanus | _____ | ❑ Meningococcal | _____ |
| ❑ Pneumonia | _____ | ❑ Shingles | _____ |
| ❑ Hepatitis A | _____ | ❑ HPV (cervical cancer) | _____ |
| ❑ Hepatitis B | _____ | | |

**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.

_____

_____

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**For Provider Only**

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

Provider Signature:_____ Date:_____