ADULT HEALTH HISTORY QUESTIONNAIRE

Welcome to our practice! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and is released only with your written permission.

Last Name:	First:	Birthdate:	Gender:

Reason for today's visit and are there any special concerns you would like to discuss?

PAST ILLNESS: Please indicate if you have been diagnosed with these conditions:

	Y	N		Y	N
High blood pressure			Migraine headaches		
Angina/chest pain			Epilepsy		
Heart attack			Stroke		
Heart murmur			Seizures		
Irregular heart rate			Glaucoma		
Coronary Artery Disease			Thyroid disease		
Asthma			Kidney disease/failure		
High cholesterol			Ulcers – Stomach		
Emphysema			Ulcers – Skin		
Tuberculosis			Gallstones		
Chronic bronchitis (COPD)			Diverticulitis		
Diabetes			Hepatitis		
Mental Illness			Cancer (what type?)		
Depression			Osteoporosis / Osteopenia		
Anxiety			Arthritis		
Dementia			Gout		

Please indicate other known medical problems:

SURGICAL HISTORY: Please list operations that you have had:

Name of Operation/Procedure:	Year	Hospital/Physician:

FAMILY HISTORY: Please indicate conditions such as heart disease, stroke, cancer, blood disorders:

Condition	Relationship to you	Age when diagnosed

Last Name:	First:	Birthdate:	Gender:

SOCIAL HISTORY/PERSONAL HABITS/RISK FACTORS:

Do you smoke?	No	Yes	How many packs/day?	What age began?
Have you ever smoked?	No	Yes	Date stopped:	
Do you use: E-cigarettes?	No	Yes	Vaping? No Yes	
Do you drink alcohol?	No	Yes	Frequency?	Amount?
Do you use drugs recreationally?	No	Yes		
Are you: ☐ married	☐ divorced	☐ single	☐ widowed	
Who do you live with?				

ALLERGIES AND REACTION: Please list medication and reaction

Medication	Reaction

Do you have an allergy to LATEX? ☐ yes ☐ no No known drug allergy ☐

MEDICATION: List all medication including: prescribed, over the counter, vitamins and supplements

Please use back of form for additional space if needed

Drug Name	Dosage	Instructions (how often taken)	Date prescribed

REVIEW OF SYSTEMS: Please indicate all that apply to you

General symptoms	**Y**	**N**	**Eyes**	**Y**	**N**	**Ears, Nose, Mouth, Throat**	**Y**	**N**
Fevers			Double vision			Hearing Loss		
Sweats			Blurry Vision			Ringing in the ear		
Chills			Sensitivity to light			Voice Changes		
Weight loss			Any vision changes			Sore throat		
Weight gain						Painful/difficult swallowing		
Fatigue						Nose bleeds		
Loss of appetite								

Continue on next page….

Last Name:	First:	Birthdate:	Gender:

REVIEW OF SYSTEMS: Please indicate all that apply to you

Skin and Breast	**Y**	**N**	**Genitourinary**	**Y**	**N**	**Psychiatric**	**Y**	**N**
Rashes			Frequent/Urgency			Depression		
Breast Cysts/Lumps			Pain with voiding			Anxiety		
New lesions/sores			Blood in urine			Hallucinations		
Breast pain			Incontinence			Suicidal ideation		
Nipple discharge			Discharge					
Hives			Flank pain			**Gastrointestinal**		
			Frequent nighttime voiding			Abdominal pain		
Allergic/Immunologic			Scrotal swelling			Nausea		
Eczema			Groin pain			Vomiting		
Hives						Vomiting blood (Hematemesis)		
Hay Fever			**Musculoskeletal**			Constipation		
Asthma			Joint pain/swelling			Diarrhea		
			Back pain/sciatica			Hemorrhoids		
Cardiovascular			Muscle aches			Rectal Bleeding		
Chest pain/heaviness			Stiffness			Heartburn		
Shortness of breath with activity			Weakness of limbs			Blood in Stool		
Shortness of breath at rest			Have any metal implants?					
Irregular heart rate						**Hematologic/ Lymphatic**		
Palpitations			**Endocrine**			Abnormal bleeding		
Angina			Heat intolerance			Spontaneous bleeding		
Edema (swelling)			Cold intolerance			Easy Bruising		
Syncope (fainting)			Frequent water intake			Clotting problems		
Poor Circulation			Excessive thirst			Transfusion problems		
			Excessive appetite			Anemia		
Respiratory			Excessive hair growth			Blood clots		
Wheezing						Had any blood transfusions?		
Pleuritic chest pain			**Neurologic**			Neck pain		
Snoring			Headache/Migraine			Groin pain		
Sleep apnea			Numbness/Tingling			Pain under arm		
Shortness of breath			Lightheadedness/fainting			Swollen glands		
Cough *(if yes check below)*			Dizziness/vertigo					
Check all that applies:			Paralysis/Paresis/Ataxia					
Dry Bloody			Weakness					
___ Green ___ White			Seizures					
___ Other (describe)			Have you had any anesthesia problems?					

Signature: _____ Date: _____