Adult Health History Questionnaire

Name:

Date Of Birth: / / **Today's Date:** / /

Please review the sections on both sides of this form. If this is your first visit to this physician, please fill this out in full. If you are not a new patient to this physician please update this form with any new information since your last visit. In all cases please complete the Review Of Symptoms And Health Problems section below.

Minor & James
Surgical Specialists
A Division of Proliance Surgeons

FAMILY

☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed	**Next Of Kin**
Number of Children	**Ages of Children**	**Occupation**

REVIEW OF SYMPTOMS AND HEALTH PROBLEMS

What specific HEALTH PROBLEMS do you want to talk about when you are seen in the clinic?

Please mark any of the following symptoms that are CURRENTLY affecting you:

CONSTITUTIONAL
- ☐ Fever
- ☐ Fatigue
- ☐ Weight change ☐ Gain ☐ Loss
- ☐ Other:

_____

HEAD, EYES, EARS, NOSE, THROAT
- ☐ Severe headaches
- ☐ Ear or hearing trouble
- ☐ Vision changes
- ☐ Other:

_____

RESPIRATORY/LUNGS
- ☐ Daily cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Other:

_____

HEART
- ☐ Chest pain
- ☐ Heart palpitations (skipped beats)
- ☐ Other:

_____

VASCULAR
- ☐ Leg swelling
- ☐ Clotting problems
- ☐ Other:

_____

STOMACH/INTESTINAL
- ☐ Frequent nausea or vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Other:

_____

IMMUNOLOGY
- ☐ Food allergies
- ☐ Environmental allergies
- ☐ Other:

_____

METABOLIC/ENDOCRINE
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Cold intolerance ☐ Heat intolerance
- ☐ Other:

_____

NERVOUS SYSTEM
- ☐ Dizziness
- ☐ Excessive nervousness
- ☐ Other:

_____

DERMATOLOGY/SKIN
- ☐ Rashes
- ☐ Itching
- ☐ Other:

_____

BONES/JOINTS/MUSCLES
- ☐ Joint pain or swelling
- ☐ Muscle weakness
- ☐ Other:

_____

BLOOD
- ☐ Excessive bleeding
- ☐ Excessive bruising
- ☐ Other:

_____

URINARY
- ☐ Blood in urine
- ☐ Unusual discharge
- ☐ Leakage of urine
- ☐ Erectile Dysfunction
- ☐ Other:

_____

GYNECOLOGY
- ☐ Changes in menstrual flow
- ☐ Excessive cramping
- ☐ Vaginal discharge
- ☐ Other:

_____

MEDICAL OVERVIEW

☐ **There have been no changes in the information below since my last visit.**

ALLERGIES **NONE ☐**

List any medications or other substances that you are allergic to or have had a reaction to:

PRESCRIPTION MEDICATIONS **NONE ☐**

List any prescription medications you are currently taking (bring bottles or a list with you if possible):

Medication	Dosage	Frequency	Medication	Dosage	Frequency

NON-PRESCRIPTION MEDICATIONS **NONE ☐**

List any non-prescription medications (laxatives, vitamins, aspirin, antacids, cold remedies, etc) you are currently taking:

VACCINATIONS (Include year if known) **Last tuberculosis skin test date:**

Flu	Shingles	HPV	Tetanus/Tdap	Meningitis	Pneumonia	Hep A/B
☐_____	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____

HEALTH HISTORY

Check if you have had any of the following?

- ☐ Anemia
- ☐ Asthma
- ☐ Emphysema
- ☐ High cholesterol
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Kidney stones
- ☐ Liver disease, jaundice, hepatitis
- ☐ Migraine
- ☐ Serious injury or accident
- ☐ Sugar Diabetes
- ☐ Thyroid gland trouble
- ☐ Tuberculosis or positive skin test to TB
- ☐ Sexually transmitted disease
- ☐ Mood problems
- ☐ Sleep Problems
- ☐ Urinary Problems
- ☐ Pregnancy: How many? _____
- ☐ History of sexual or physical abuse
- ☐ Menopause: Age _____
- ☐ Surgery: Type_____ Date _____
- ☐ Cancer: Type_____ Date _____

Preventive History (Year or N/A)

	Normal	Abnormal	Past Abnormal
_____ Last Pap Smear	☐	☐	☐
_____ Last Bone Density	☐	☐	☐
_____ Last Colonoscopy	☐	☐	☐
_____ Last Mammogram	☐	☐	☐
_____ Last PSA Test	☐	☐	☐

List your blood relatives have had any of the following?

Heart attack or heart disease _____

Diabetes _____

High blood pressure _____

Mental or emotional disease _____

High cholesterol _____

Alcohol or substance abuse _____

Breast Cancer _____ Ovarian Cancer _____

Colon Cancer _____ Prostate Cancer _____

SOCIAL HISTORY

Tobacco:
☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Chew
Years: _____ Daily Amount :_____

Caffeinated Beverages:
Cups per day: _____ Type: _____

Alcohol: Average drinks/week: _____

Recreational Drug Use:

Type Used: _____ ☐ Past ☐ Current

Sexual Orientation (Do you have sex with):
☐ Men ☐ Women ☐ Both ☐ Not sexually active

☐ Do you use contraception?
☐ Do you practice safe sex?

Exercise: Type _____ Amount _____
☐ Do you diet?

Hours of sleep per night _____ Meals per day _____