ADULT HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are confidential and will be part of your medical record.

Today's Date:		
Legal Name (*Last, First, M.I.*):	Preferred Name (*Optional)* :	DOB:
Sex Assigned at Birth: _____M _____F	Sex (Legal): _____ M _____ F _____Non-Binary _____Unknown	

Current Medications (*Prescription and Over the Counter*)**:**

Medication Name	Dose	Frequency Taken

Allergies (*List any drugs, medications, or allergens to which you are allergic*): _____ **No Known Allergies**

Name of Medication, Food or Allergen	Reaction

Hospitalization & Surgery: *Check all that apply*

Surgery	Yes	Date	Surgery	Yes	Date
Appendectomy	☐		Hysterectomy	☐	
Brain Surgery	☐		Joint Replacement	☐	
Breast Surgery	☐		Ovary Removal	☐	
Coronary Artery Bypass Graft	☐		Prostate Surgery	☐	
Cholecystectomy	☐		Sex Reassignment Surgery	☐	
Colon Surgery	☐		Small Intestine Surgery	☐	
Cosmetic Surgery	☐		Spine Surgery	☐	
Cesarean Section	☐		Thyroid Surgery	☐	
Dental Surgery	☐		Tonsillectomy	☐	
Ear Tubes	☐		Tubal Ligation	☐	
Eye Surgery	☐		Valve Replacement	☐	
Foot Surgery	☐		Vasectomy	☐	
Fracture Surgery	☐		Vein Surgery	☐	
Hernia Repair	☐		Other:	☐	

Medical History: *Check all that apply*

Condition	Yes	Date Diagnosed	Condition	Yes	Date Diagnosed
Allergies (seasonal, food, drug)	☐		Heart Murmur	☐	
Anemia	☐		Hyperlipidemia	☐	
Anxiety	☐		High Blood Pressure	☐	
Arthritis	☐		Kidney Disease	☐	
Asthma	☐		Kidney Stones	☐	
Autoimmune Disease	☐		Leukemia	☐	
Bipolar Disorder	☐		Lung Cancer	☐	
Breast Cancer	☐		Migraine Headaches	☐	
Cancer	☐		Heart Attack (MI)	☐	
Cardiovascular Disease	☐		Nerve/Muscle Disease	☐	
Celiac Disease	☐		Osteoporosis	☐	
Congestive Heart Failure (CHF)	☐		Prostate Cancer	☐	
Clotting Disorder	☐		Seizures	☐	
Colon Cancer	☐		Skin Cancer	☐	
COPD	☐		Sleep Apnea	☐	
Dementia	☐		Stroke (CVA)	☐	
Depression	☐		Substance Abuse	☐	
Diabetes Mellitus	☐		Thyroid Disease	☐	
Eye Disease	☐		Tremors	☐	
Gastroesophageal Reflux	☐		Ulcers	☐	
Glaucoma	☐		Other:	☐	
Gout	☐		Other:	☐	

Family History (Blood Relatives):

Family Member	Medical Condition(s)
Mother	
Father	
Sister(s)	
Brother(s)	
Other:	

Specialist Care: *Please list any specialists you have seen in the past 5 years*

Specialty	Name of Specialist	City/Location

Health Habits and Personal Safety: *All questions are optional and will be kept strictly confidential*

Exercise (*Choose one)*	Sedentary (Little to no exercise on a regular basis) ☐
	Mild exercise (i.e. climb stairs, walk 3 blocks, golf) ☐
	Occasional vigorous exercise (i.e. work or recreation, less than 4x/week) ☐
	Regular vigorous exercise (i.e., work or recreation, 4x/week for 30+ minutes) ☐
Diet	How would you classify your diet?
	Do you drink caffeinated beverages?
	If so, what kind and how many drinks per day?
Alcohol	Do you drink Alcohol?
	If yes, what kind?
	How many drinks per week?
Tobacco	Do you use tobacco? Y N Cigarettes? Y N Pack per day: _____ Chew? Y N #/Day: _____
	Do you use e-cigarettes? Y N #/Day: _____ Cigars? Y N #/Day: _____
	Do you Vape? Y N #/Day: _____ Are you interested in quitting? Y N
	# of years: _____ Year quit (if applicable): _____
Drugs	Do you currently use recreational or street drugs? Y N
	Do you currently use marijuana for any reason, including medical? Y N

Sexual Activity	Are you sexually active? Y N
	If yes, Please describe what kind of sexual activity you engage in, how your partner(s) identify and if you utilize any form of safe sex practices?
	If you are sexually active, are you trying to get pregnant? Y N
	If not trying for pregnancy, list contraceptive or barrier method used, if applicable:
Social History	What is your Sexual Orientation?
	Lesbian or Gay _____ Straight (not lesbian or gay) _____ Bisexual _____
	Something else _____ Don't Know _____ Choose not to disclose _____
	Relationship Status:
	Single _____ Married _____ Domestic Partnered, living together _____
	Partnered, not living together _____ Separated _____ Divorced _____ Widowed _____
	Other:
	Do you have any children? Y N
	If so, how many and what are their ages?
	Do you work outside of the home? Y N | Retired? Y N
	What do (or did) you do for employment?
OB/Gyn History (Females Only)	How old were you when you had your first period?
	When was your last Pap Smear (Cervical Cancer Screening)?
	Was it normal (negative)? Y N
	Have you ever had an abnormal pap smear? Y N
	If yes, When?
	Have you ever been pregnant before? Y N
	If yes, total number of pregnancies?
	Number of deliveries?
	Number of vaginal births?
	Number of cesareans?

Health Care Maintenance:

Do you have Advanced Healthcare Directive? Y N
Do you have a Durable Power of Attorney? Y N If yes, who? _____
Date of last Colonoscopy (Age 45 and older)?
Date of last Mammogram (Age 40 and older)?
Date of last Bone Density (Age 65 and older)?