PeaceHealth
Medical Group

ADULT HEALTH QUESTIONNAIRE

NAME: _____ **DATE OF BIRTH:** _____ **TODAY'S DATE:** _____

REASON FOR TODAY'S VISIT: List in order of importance to you	**ALLERGIES:** List any allergies to medications and/or foods
MEDICINES: List all medicines, herbs, nutritional supplements	
PAST HEALTH:	
MEDICAL PROBLEMS	

SURGERIES:			**OTHER HOSPITALIZATIONS:**		
YEAR	REASON	HOSPITAL	YEAR	REASON	HOSPITAL

FAMILY HISTORY:

Has any of your family / blood relatives ever had any of the following conditions? ***Complete all columns.***

	NO	YES	Relationship to Patient		NO	YES	Relationship to Patient
Heart attack				Obesity			
Stroke				Arthritis			
High blood pressure				Suicide			
Diabetes				Abuse:			
Cancer				Alcohol			
Asthma				Drug			
Hay fever				Physical			
Mental illness				Sexual			
Tuberculosis (TB)				Other			

List below at what age members of your family died and the cause of their deaths.

	Age if Living	Age at time of Death	Cause of Death
Mother			
Father			
Sibling(s)			
Grandmother (Maternal)			
Grandfather (Maternal)			
Grandmother (Paternal)			
Grandfather (Paternal)			

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SOCIAL HISTORY

Marital Status: ❑ Single ❑ Married / Significant Other ❑ Separated ❑ Divorced ❑ Widowed

Number in household:	Number of children:
Religious Preference (or none):	Occupation:

HABITS

DO YOU NOW USE, **OR HAVE YOU EVER USED,** the following:

	NO	YES		NO	YES
Seatbelts			Alcohol		
Caffeine			Street Drugs		
Tobacco					

Do you need assistance for DAILY ACTIVITIES? ❑ No ❑ Yes

If yes, please check from the following needs: ❑ Cooking ❑ Grocery Shopping ❑ Dressing ❑ Bed ❑ Using Toilet ❑ Getting up from a chair ❑ Taking medications

IMMUNIZATIONS: ❑ Tetanus ❑ Pneumonia ❑ Influenza ❑ Other

HEALTH MAINTENANCE

Have you ever had a: ❑ Colonoscopy ❑ Flex Sigmoidoscopy ❑ Bone Density (Dexa scan) ❑ Hemoccult Card

PERSONAL SAFETY

	NO	YES		NO	YES
Do you live alone?			Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this with your provider?		
Do you have frequent falls?					
Do you have any vision or hearing loss?					
Do you have an Advance Directive and/or Living Will?					
Would you like information on the preparation of these?					

SEX

	NO	YES		NO	YES
Are you sexually active?			Illness related to the Human Immunodeficiency Virus (HIV) such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk for this illness?		
If yes, are you trying for a Pregnancy?					
If not trying for a Pregnancy list contraceptive or barrier method used?					

FEMALES ONLY

Age of first period?	**REPRODUCTIVE HISTORY**
First day of last NORMAL period (LNMP):	Have you ever been pregnant? ❑ No ❑ Yes
Length of cycle? / Days of flow?	Total number of pregnancies? _____
Periods are: ❑ regular ❑ irregular Maximum # pads / tampons used in 24 hours? _____	a) # Live Births: _____ d) # Still Births: _____ b) # Full Term _____ e) # Miscarriages / Abortions: _____
Menstrual cramps: ❑ none ❑ mild ❑ moderate ❑ severe	c) # Premature: _____ f) # Ectopic / Tubal: _____
Date of last Pap Smear: _____ Normal: ❑ Yes ❑ No	
Ever had an abnormal Pap Smear? ❑ No ❑ Yes	Last Delivery Date:
Date of last mammogram: _____ Normal: ❑ Yes ❑ No	Number of children now living?
Experienced any recent breast pain/tenderness, lumps or nipple discharge? ❑ Yes ❑ No	Are you breast-feeding now? ❑ No ❑ Yes

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MALES ONLY

	NO	YES		NO	YES
Do you usually get up to urinate during the night? If yes, # of times _____			Have you had any kidney, bladder or prostate infections within the last 12 months?		
Do you feel pain or burning with urination?			Do you have any problems emptying your bladder completely?		
Any blood in your urine?			Any difficulty with erection or ejaculation?		
Do you feel burning discharge from penis?			Any testicle pain or swelling?		
Has the force of your urination decreased?			Date of last prostate & rectal exam?_____/_____/_____		

REVIEW OF SYSTEMS

SYMPTOMS: Do you have concerns or current complaints? ***Please complete all columns.***

GENERAL

	NO	YES
Fever		
Chills		
Sweats		
Loss of appetite		
Fatigue		
Weakness		
Weight loss		
Sleep disorder		
Other:		

If you answered YES to any of the above question, please explain below:

EYES

	NO	YES
Vision loss		
Double vision		
Eye irritation		
Blurring		
Eye pain		
Eye discharge		
Light sensitivity		
Other:		

If you answered YES to any of the above question, please explain below:

EARS, NOSE AND THROAT

	NO	YES
Ringing in the ears		
Ear discharge		
Ear ache		
Decreased hearing		
Nasal congestion		
Nose bleeds		
Runny nose		
Difficulty swallowing		
Hoarseness		
Sore throat		
Other:		

If you answered YES to any of the above question, please explain below:

CARDIOVASCULAR

	NO	YES
Near fainting		
Chest pain or discomfort		
Racing/skipping heart beats		
Fatigue		
Lightheadedness		
Shortness of breath with exertion		
Palpitations		
Other:		

If you answered YES to any of the above question, please explain below:

	NO	YES
Swelling of hands or feet		
Difficulty breathing while lying down		
Fainting		
Leg cramps with exertion		
Bluish discoloration of lips or nails		
Weight gain		
Other:		

If you answered YES to any of the above question, please explain below:

RESPIRATORY

	NO	YES
Sleep disturbances due to breathing		
Cough		
Shortness of breath		
Coughing up blood		
Chest		
Chest discomfort		
Wheezing		
Excessive sputum		
Excessive snoring		
Other:		

If you answered YES to any of the above question, please explain below:

GASTROINTESTINAL (GI)

	NO	YES
Excessive appetite		
Loss of appetite		
Indigestion		
Vomiting blood		
Nausea		
Vomiting		
Yellowish skin color		
Gas		
Abdominal pain		
Abdominal bloating		
Hemorrhoids		
Diarrhea		
Change in bowel habits		
Constipation		
Dark tarry stools		
Bloody stools		
Other:		

If you answered YES to any of the above question, please explain below:

GENITOURINARY (GU)

	NO	YES
Vaginal discharge		
Blood in urine		
Urinary frequency		
Inability to empty bladder		
Urinary urgency		
Kidney pain		
Trouble starting urinary stream		
Painful urination		
Night time urination		
Inability to control bladder		
Genital sores		
Lack of sexual drive		
Excessive heavy periods		
Missed periods		
Unusual urinary color		
Abnormal vaginal bleeding		
Pelvic pain		

If you answered YES to any of the above question, please explain below:

MUSCULOSKELETAL

	NO	YES
Muscle cramps		
Joint pain		
Joint swelling		
Presence of joint fluid		
Back pain		
Stiffness		
Muscle weakness		
Arthritis		
Gout		
Loss of strength		
Muscle aches		
Other:		

If you answered YES to any of the above question, please explain below:

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DERMATOLOGICAL (SKIN)					
	NO	YES		NO	YES
Excessive perspiration			Skin Cancer		
Night sweats			Itching		
Suspicious lesions			Changes in color of skin		
Changes in nail beds			Flushing		
Dryness			Rash		
Poor wound healing			Other:		
Unusual hair distribution					
If you answered YES to any of the above questions, please explain below:					

PSYCHOLOGICAL					
	NO	YES		NO	YES
Sense of great danger			Depression		
Anxiety			Thoughts of violence		
Thoughts of suicide			Frightening visions or sounds		
Mental problems			Other:		
If you answered YES to any of the above questions, please explain below:					

ENDOCRINE					
	NO	YES		NO	YES
Excessive hunger			Excessive thirst		
Cold intolerance			Weight change		
Heat tolerance			Other:		
Excessive urination					
If you answered YES to any of the above questions, please explain below:					

HEMATOLOGIC (BLOOD)					
	NO	YES		NO	YES
Enlarged lymph nodes			Abnormal bruising		
Bleeding			Fevers		
Skin discoloration			Other:		
If you answered YES to any of the above questions, please explain below:					

NEUROLOGIC		
	NO	YES
Difficulty with concentration		
Poor balance		
Headaches		
Disturbances in coordination		
Numbness		
Inability to speak		
Falling down		
Tingling		
Brief paralysis		
Visual disturbances		
Seizures		
Weakness		
Sensation of room spinning		
Tremors		
Fainting		
Excessive daytime sleeping		
Memory loss		
Other		
If you answered YES to any of the above questions, please explain below:		

ALLERGY/IMMUNOLOGY		
	NO	YES
Persistent infection		
Hives or rash		
Seasonal allergies		
HIV exposure		
Other		
If you answered YES to any of the above questions, please explain below:		

Patient Signature: _____ **Date:** _____

Reviewed by: _____ ❑ Scan (.hxrev)