

## ADULT MEDICINE QUESTIONNAIRE

Date \_\_\_\_\_ MRN \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Circle one:    Single            Married            Divorced/Separated            Widow/Widower

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Prior physicians: \_\_\_\_\_ Occupation: \_\_\_\_\_

### FAMILY HISTORY

#### PARENTS

Is your mother alive? Yes No How old is she? \_\_\_\_\_

If deceased, what age and what did she die from? \_\_\_\_\_

History of serious health problems? Yes No If yes, what? \_\_\_\_\_

Is your father alive? Yes No How old is he? \_\_\_\_\_

If deceased, what age and what did he die from? \_\_\_\_\_

History of serious health problems? Yes No If yes, what? \_\_\_\_\_

BROTHERS AND SISTERS            Number of Brothers \_\_\_\_\_ Number of Sisters \_\_\_\_\_

Serious health problems or cause of death \_\_\_\_\_

Is there a history in your family of: (circle)

Diabetes

High Blood Pressure

Breast Cancer

Bleeding Disorders

Ulcerative Colitis or Crohn's Disease

Ovarian Cancer

Asthma or Allergies

Heart Attack or Bypass before age 50

Colon Cancer

Migraines

Inherited or genetic diseases

Prostate Cancer

Sickle Cell Anemia

### MEDICAL HISTORY

List any and all known medical problems:

List any and all surgeries or hospitalizations with approximate dates:

List all medications (including amount and doses per day) including over-the-counter medications, vitamins, herbs, supplements, etc:

List any medications you are allergic to:

Date of last Tetanus Booster: \_\_\_\_\_ Date of last Tuberculosis Test (PPD): \_\_\_\_\_

Do you wear glasses?            Yes    No            Date of last eye exam: \_\_\_\_\_

How is your hearing?            Good            Fair            Poor

Patient Name \_\_\_\_\_ MRN \_\_\_\_\_

HAVE YOU EVER HAD ANY OF THE FOLLOWING: (circle)

- |  |                     |   |                     |
|--|---------------------|---|---------------------|
| Chicken Pox  | Heart Murmur        | Psychiatric Problem                       | Radiation Treatment |
| Rheumatic Fever  | Irregular Pulse     | Seizure (epilepsy)                        | Kidney stone        |
| Pneumonia  | Diabetes            | Anemia (low blood count)                  | Easy bleeding       |
| Hepatitis  | High blood pressure | Concussion                                | Sickle Cell Anemia  |
| HIV/AIDS   | Fainting spell      | Ulcer                                     | Blood Transfusion   |
| Cancer   | High Cholesterol    | Asthma                                    |                     |
| Exposure to toxic chemicals, asbestos, or silicon dust |                     | Exposure to person with tuberculosis (TB) |                     |

PHYSICAL CONDITION:

Do you exercise regularly: Yes No If yes, doing what? \_\_\_\_\_  
Current weight: \_\_\_\_\_ Weight 2 years ago: \_\_\_\_\_

TOBACCO:

Do you smoke or use tobacco? Yes No Have you ever smoked? Yes No  
How many packs per day? \_\_\_\_\_ How long have you smoked? \_\_\_\_\_  
When did you quit smoking? \_\_\_\_\_

ALCOHOL:

Have you ever felt you ought to cut down on your drinking? Yes No  
Have people annoyed you by criticizing your drinking? Yes No  
Have you felt bad or guilty about your drinking? Yes No  
Have you ever had a drink first thing in the morning? Yes No

DRUGS: Do you smoke marijuana? Yes No Do you use any other drugs? Yes No

SEXUALITY: Number of sexual partners in your lifetime: \_\_\_\_\_  
Have you ever had a sexually transmitted disease (VD)? Yes No

WOMEN ONLY:

Age of first period: \_\_\_\_\_ Date of last pap smear: \_\_\_\_\_  
Last menstrual period: \_\_\_\_\_ Date of onset of menopause: \_\_\_\_\_  
Number of times pregnant: \_\_\_\_\_ Number of times delivered: \_\_\_\_\_  
Date of last mammogram: \_\_\_\_\_ Date of last bone density test: \_\_\_\_\_

DO YOU CURRENTLY HAVE PROBLEMS WITH: (circle)

- |                            |                     |                            |                         |
|----------------------------|---------------------|----------------------------|-------------------------|
| Severe headaches           | Wheezing            | Depression                 | Abdominal pain          |
| Migraines                  | Shortness of breath | Insomnia                   | Indigestion / heartburn |
| Nosebleeds                 | Heart palpitations  | Nervousness or anxiety     | Diarrhea                |
| Ringing in ears            | Chronic cough       | Frequent urination         | Constipation            |
| Dizziness                  | Coughing up blood   | Urination at night         | Difficulty swallowing   |
| Back pain                  | Chest pain          | Painful urination          | Rashes                  |
| Arthritis                  | Blood clots         | Ankle swelling             | Hives                   |
| Pain in legs while walking |                     | Black stool/blood in stool |                         |

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date