

Adult Medical History Questionnaire



Name: _____

Date of Birth: _____

Phone #: _____

Please list any **medical problems**, past or present, that you would like included in your chart (all information is kept confidential). This should include problems like high blood pressure, diabetes, ulcers, anxiety, etc.:

Please list previous **surgeries** and approximate dates:

Please list any **hospitalizations** you have had (other than for surgeries or ER visits) and the reason hospitalized, along with approximate dates:

Please list all of your **current medications**, including dosage. Also include any over-the-counter medications or vitamins:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Drug Allergies: _____

Other Allergies: _____

continued....

Marital Status:

Single Married Divorced Separated Widowed Live w/Significant Other

Children's Names and Ages (if applicable):

How many people, including yourself, live in your household? _____

What is the relationship of the other people in your household (for example: spouse, son, mother, cousin, friend, roommate, etc.)?

Employment Status (circle one):

Full-time Part-time Unemployed Retired Disabled Homemaker Student

If employed, please list name of employer and job title:

Personal Habits:

Do you currently use tobacco? _____.

If yes, what kind: Cigarettes Chew Snuff Cigars

If you smoke, how many packs per day and for how many years? _____

If no, have you smoked cigarettes in the past? _____

If yes, how many years did you smoke, and when did you quit?

Do you drink alcohol? _____.

If yes, approximately how many drinks per week:

0-1 2-4 5-7 8-10 11-14 >14

Are you currently following any special diet (for example: vegetarian, low cholesterol, low salt, etc)?

Do you currently exercise? _____

If yes, list what kind of exercise and how often:

Family History: Please list illnesses, if known, pertaining to relatives listed below.

** If you are adopted or do not know any of your family's medical history, please check here: _____

Mother: Alive Deceased List current age, or the age she died: _____

Medical problems, if any:

Father: Alive Deceased

List current age, or the age he died: _____

Medical problems, if any: _____

Brothers:

How many? _____ List current ages if applicable: _____

Medical problems, if any: _____

Sisters:

How many? _____ List current ages if applicable: _____

Medical problems, if any: _____

List any major medical problems that your grandparents or aunts/uncles have, especially anything pertaining to heart disease, diabetes, stroke, or cancers:

For men and women over 50 years of age:

Have you had a baseline colonoscopy done to screen for colon cancer? _____

If yes, approximate date and any abnormalities (such as polyps): _____

For women only:

How many pregnancies have you had? _____ How many living children? _____

Approximate date of your last pap smear if done outside of our clinic: _____

Have you ever had an abnormal pap smear? _____ If yes, how long ago? _____

Have you ever had a sexually transmitted disease? _____ If yes, what? _____

For women over 40 years of age:

Approximate date of last mammogram: _____

For postmenopausal women:

Have you ever had a bone density test? _____

If yes, approximate date and results: _____