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: ____________________________________