Adult Patient Medical Questionnaire

Date: _____

Name: _____ _____ _____ Date of Birth _____

Last *First* *Middle* *DD/MM/YYYY*

CURRENT MEDICAL PROBLEMS

List any current problems or conditions.

1) _____ 7) _____
2) _____ 8) _____
3) _____ 9) _____
4) _____ 10) _____
5) _____ 11) _____
6) _____ 12) _____

ALLERGIES

List any allergies to medication, X-ray dyes, or food

Allergy	Reaction

Rx

Local Pharmacy: _____ Mail Order Pharmacy: _____

MEDICATIONS

List any medication that you currently take, including over-the-counter.

Name	Strength	Direction	Prescribed by

Patient Name:_____ **Date of Birth:** _____

PAST MEDICAL HISTORY (CONTINUED)

Last Eye Exam: _____

Last Dental Exam: _____

Past Surgeries/ Procedures

	Surgery	Date
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____

List Any Other Hospital Stays:

	Reason	Date
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____

Anesthesia History

Any problems with anesthesia? ☐ NO ☐ YES (If yes, please list)

_____

Physicians/Practitioners You Currently See:

	Name	Specialty
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____

Patient Name: _____ **Date of Birth:** _____

FAMILY HISTORY

Please list any health problems and causes of death if applicable.

Family Member	Age	History
Father		
Mother		
Brother(s)		
Sister(s)		
Mother's father		
Mother's mother		
Father's father		
Father's mother		

SOCIAL HISTORY

Do you drink alcohol?..... ☐No ☐Yes
If yes, how much? _____
Are you sexually active?..... ☐No ☐Yes
If yes, what form of contraception do you use? _____
Do you consume caffeine?..... ☐No ☐Yes
If yes, how much per day? _____
Diet: ☐Balanced ☐Vegetarian ☐Diabetic ☐Low Salt ☐Low Fat ☐Low Carb ☐Other: _____

Education: ☐High School ☐College ☐Some College ☐Trade School ☐Other: _____
Do you do some form of regular exercise every day? ..... ☐No ☐Yes
If yes, how much? _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed Other: _____

Occupation: _____

List everyone in your household, including pets:

_____ _____
_____ _____
_____ _____

Do you participate in any activities that put you at risk of getting HIV?..... ☐No ☐Yes
Do you smoke or chew tobacco:... ☐No ☐Yes
If yes, how much: _____
Spouse's occupation: _____
Do you use recreational drugs:... ☐No ☐Yes
If yes, what do you use? _____

HEALTH MAINTENANCE

Please record the last year you had the following. If you do not know, leave blank.

Hep A _____
Hep B _____
Flu vaccine (shot) _____
Pneumonia vaccine (shot) _____
Tuberculosis Test _____
Positive PPD _____
Tetanus Diphtheria vaccine (shot) _____
TdaP _____
Meningococcal _____
MMR _____
Zostavax _____

Bone Density Scan _____
Breast Exam _____
Cardiac Stress Test _____
Colonoscopy _____
EKG _____
Hearing Exam _____
Mammogram _____
Eye Exam _____
Pelvic Exam _____
PAP Smear/GYN _____
Physical Exam _____

Patient Name: _____ **Date of Birth:** _____

MENSTRUAL HISTORY

(Female Patients Only)
Date of last menstrual period:_____
Amount: ☐ Normal ☐ Light ☐ Heavy ☐ Other:
Duration: _____ days
Are periods regular? ☐ No ☐ Yes
How many days apart are periods? _____
Age of onset of period:_____
Age of cessation of period: _____
Any abnormal PAP smears? ☐ No ☐ Yes
If yes, when:_____
Diagnosed with any STD's? ☐ No ☐ Yes
If yes, what _____

PAST PREGNANCIES

(Female Patients Only)
Please note the number of:

Total Pregnancies: _____
Full term births: _____
Premature births: _____
Abortions: _____
Abortions-spontaneous- _____
Pregnancies-Ectopic: _____
Pregnancies-Multiple births: _____
Living; _____

REVIEW OF SYSTEMS

Please check if you have had problems with or are presently experiencing problems with any of the following:

Skin
☐ Skin diseases
Eyes
☐ Eye diseases
ENT
☐ Hay fever
☐ Head or neck
Neck
☐ _____
Respiratory
☐ Shortness of breath
☐ Asthma
☐ Bronchitis
☐ Pneumonia
☐ Persistent cough
Cardiovascular
☐ High blood pressure
☐ Heart disease
☐ Chest Pain
☐ Swollen ankles
☐ Palpitations
☐ Lightheadedness

Gastrointestinal
☐ Abdominal discomfort
☐ Indigestion
☐ Nausea
☐ Vomiting
☐ Constipation
☐ Diarrhea
☐ Blood in stool
☐ Ulcers
☐ Change in bowel habits
☐ Unexplained weight gain/loss
☐ Hemorrhoids
☐ Gall bladder disease
☐ Colitis
Genitourinary (Female)
☐ Frequent urination
☐ Kidney diseases
☐ Kidney stones
☐ Difficulty urinating
Genitourinary (Male)
☐ Frequent urination
☐ Kidney diseases
☐ Kidney stones
☐ Difficulty Urinating

Musculoskeletal
☐ Arthritis
☐ Low back problems
☐ Gout
Neurological
☐ Headache
Endocrine
☐ Diabetes
☐ Thyroid Disease
Psychiatric
☐ Anxiety
☐ Depression
☐ Alcohol abuse
☐ Drug abuse
Hematologic/Oncologic
☐ Cancer
☐ Blood disorders
☐ Anemia
Infectious Disease
☐ Venereal diseases
☐ Hepatitis or Jaundice
☐ T.B. (Tuberculosis)
☐ Rheumatic Fever
Breast
☐ _____

OTHER

Do you have an advanced directive (living will)? ☐ No ☐ Yes
Notes: _____
_____
_____
Authorized Signature: _____ Date: _____
Reviewed by: _____ Date: _____