Adult Patient Questionnaire

NAME:

DOB:

INTERPRETER NEEDED? ☐ NO ☐ YES,_____

a. Medications/Allergies

List any allergy(ies) and reaction(s) you have: ☐ NONE _____

_____

List any medications you are currently taking: ☐ NONE

Medicine:	Dose:	How often:	5.		
1.			6.		
2.			7.		
3.			8.		
4.			9.		

b. Immunizations *(approximate dates)*

Do you have your immunization record? ☐ NO ☐ YES

Last flu shot: _____ ☐ NEVER Last Pneumonia shot: _____ ☐ NEVER Last Tetanus shot: _____ ☐ NEVER

c. PHQ2

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday
2. Feeling down, depressed or hopeless ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday

d. Gynecological Health *(Females only)*

When was the first day of your last menstrual period? _____

Are you currently pregnant? ☐ NO ☐ YES Are you currently breastfeeding? ☐ NO ☐ YES

How many pregnancies have you had in the past? ____

How many of your pregnancies were: C-sections ____ Vaginal deliveries ____ Miscarriages ____ Abortions ____

e. Health History

Have you ever had or are you being treated for any of the following chronic conditions?

Allergies/Hay Fever	☐ NO ☐ YES	COPD (Emphysema)	☐ NO ☐ YES	Heart Attack	☐ NO ☐ YES
Anemia	☐ NO ☐ YES	Depression	☐ NO ☐ YES	Osteoporosis	☐ NO ☐ YES
Angina	☐ NO ☐ YES	Diabetes	☐ NO ☐ YES	Kidney Problems	☐ NO ☐ YES
Anxiety	☐ NO ☐ YES	High Cholesterol	☐ NO ☐ YES	Seizure Disorder	☐ NO ☐ YES
Arthritis	☐ NO ☐ YES	Gallbladder Disease	☐ NO ☐ YES	Stroke	☐ NO ☐ YES
Asthma	☐ NO ☐ YES	GERD (Reflux, Heartburn)	☐ NO ☐ YES	Thyroid Disease	☐ NO ☐ YES
Blood Clots	☐ NO ☐ YES	Migraine Headaches	☐ NO ☐ YES	Enlarged Prostate	☐ NO ☐ YES
Cancer	☐ NO ☐ YES	Heart Disease	☐ NO ☐ YES	Impotence	☐ NO ☐ YES
Breast Cancer	☐ NO ☐ YES	Hepatitis	☐ NO ☐ YES	Bleeding Disorders	☐ NO ☐ YES
Gynecologic Cancer	☐ NO ☐ YES	Liver Disease	☐ NO ☐ YES	HIV	☐ NO ☐ YES
Colon Cancer	☐ NO ☐ YES	High Blood Pressure	☐ NO ☐ YES	Joint Replacement	☐ NO ☐ YES

List any surgeries you had: ☐ NONE _____

_____

f. Health Maintenance

Last Cholesterol: _____ Last Pap Smear: _____

Last Bone Density: _____ Last Mammogram: _____

Last Colon Cancer Screen: _____ ☐ Colonoscopy ☐ Sigmoidoscopy ☐ Stool Card

g . Family History *(list parents, sibling and children only)*

Alcoholism	☐ NO ☐ YES,_____	High Cholesterol	☐ NO ☐ YES,_____
Asthma	☐ NO ☐ YES,_____	Mental Illness	☐ NO ☐ YES,_____
Cancer	☐ NO ☐ YES,_____	Stroke	☐ NO ☐ YES,_____
Heart Disease	☐ NO ☐	Drug Abuse	☐ NO ☐ YES,_____
Diabetes	☐ NO ☐ YES,_____	Blood clots	☐ NO ☐ YES,_____
		Other	☐ NO ☐ YES,_____

h. Social History

Do you smoke/vape/other tobacco? ☐ NO ☐ YES ☐ FORMER Type: _____ Daily Amount: _____

Do you drink alcohol? ☐ NO ☐ YES ☐ BEER ☐ WINE ☐ HARD LIQUOR Daily Amount: _____

Do you drink caffeine? ☐ NO ☐ YES ☐ COFFEE ☐ TEA ☐ SODA ☐ TABLETS ☐ OTHER Daily Amount: _____

Country of Birth: _____

Occupation:_____ ☐ Retired ☐ Unemployed

Occupational hazards at your place of employment:

☐ Asbestos ☐ Chemicals ☐ Excessive noise ☐ Potentially toxic fumes Other, _____

Education Level Completed/Degree: _____

Children? _____ Number of Sons:_____ Number of Daughters:_____

How would you describe your activity level? ☐ SEDENTARY ☐ MODERATE ☐ VIGOROUS

Health Club Member? ☐ NOW ☐ PREVIOUSLY ☐ NEVER

Type of exercise: _____ Exercise frequency/hours per week? _____

Do you have firearms at home? ☐ NO ☐ YES

Do you use any other drugs? ☐ NO ☐ YES ☐ FORMERLY Type/Frequency/Amount: _____

Whom do you partner with? ☐ MEN ☐ WOMEN ☐ BOTH

Do you have Advances Directive and/or a Living Will in place? ☐ NO ☐ YES

i. Dental Health

Do you brush your teeth? ☐ NO ☐ YES Do you floss your teeth? ☐ NO ☐ YES

Do you have a dentist? ☐ NO ☐ YES Date of your last dental visit: _____

Thank you for taking the time to tell us about your health history.

HealthPoint