

Initial Adult History Questionnaire

Today's Date: _____ Patient Name: _____ Preferred Name _____ DOB: _____

Gender from Birth _____ Gender Identity _____ How did you hear about our office? _____

Please list specialists you are seeing (including Gyne): _____

Reason for today's visit: _____

Do you have a medical advance directive or a living will? Yes No (If yes, please provide our office with a copy.)

Do you need any of the following: (Please circle)

Disability Paperwork Return to work note Surgical Clearance Prescription Refills Beside Commode Rolling Walker Cane

Are you interested in any of the following? (Please Circle) PrEP - HIV Prevention HIV Screening Hepatitis C Screening STD Screening

Weight Loss Diabetes Screening Preventing Planning Pregnancy Prevention Cervical Cancer Vaccine Shingles Vaccine

Past Medical History

Abnormal Heart Rhythm	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Heart Attack or blockages	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Acid Reflux	<input type="checkbox"/> Currently <input type="checkbox"/> Past	High Blood Pressure	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Allergies/ Sinus Trouble	<input type="checkbox"/> Currently <input type="checkbox"/> Past	High Cholesterol	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Anemia	<input type="checkbox"/> Currently <input type="checkbox"/> Past	HIV	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Anxiety	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Joint Pain (specify) _____	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Asthma	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Kidney Disease	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Back Pain	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Liver Disease	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Bipolar Disorder	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Lupus	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Cancer Specify: _____	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Neuropathy	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Congestive Heart Failure	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Sarcoidosis	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Depression	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Stomach Ulcers	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Diabetes	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Stroke	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Emphysema	<input type="checkbox"/> Currently <input type="checkbox"/> Past	_____	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Fibromyalgia	<input type="checkbox"/> Currently <input type="checkbox"/> Past	_____	<input type="checkbox"/> Currently <input type="checkbox"/> Past

Family History

Please use the following key: MGM- Maternal Grandmother, PGM- Paternal Grandmother, MGF- Maternal Grandfather, PGF- Paternal Grandfather, M-Mother, F-Father, A- Aunt , U- Uncle, B-Brother, S- Sister, C- Cousin

Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Congestive Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Dialysis for Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Cancer, (Type): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____

Additional Family History: _____

Social History

What is your occupation? _____

Sexual Partner Preference Males Females Have a significant other? Yes No Marital Status: _____

Do you have any children? Yes No If yes, how many? _____

Have you ever used tobacco? Currently Formerly Occasionally Never If yes: Packs per day _____ How many years? _____

Do you drink alcohol? Currently Formerly Occasionally Never

If yes, what do you drink? _____ How much? _____ How often? _____

Have you ever done drugs? Currently Formerly Occasionally Never If yes, which? _____

Reproductive History (Women Only)

Do you have regular monthly periods? Yes No
 Number of days in cycle? _____
 Heavy Bleeding? Yes No
 Painful? Yes No
 What age did you start having periods? _____
 What age did you stop having periods? _____ Reason: _____
 Have you ever been pregnant? Yes No Number of pregnancies _____ Number of Children _____ Complications _____

Past Surgical History

Please check any surgeries you have had:

<input type="checkbox"/> Amputation , Please specify: _____	Date: _____
<input type="checkbox"/> Appendix Removed	Date: _____
<input type="checkbox"/> Back Surgery Please specify: _____	Date: _____
<input type="checkbox"/> Gallbladder Removed	Date: _____
<input type="checkbox"/> Heart Bypass/ Stent	Date: _____
<input type="checkbox"/> Hysterectomy - <input type="checkbox"/> Partial or <input type="checkbox"/> Total Reason? _____	Date: _____
<input type="checkbox"/> Mastectomy	Date: _____
<input type="checkbox"/> Tonsillectomy	Date: _____

Please list any other surgeries with details:

Medication

<u>Name of Medication</u>	<u>Dose</u>	<u>Number of times per day</u>	<u>Name of Medication</u>	<u>Dose</u>	<u>Number of times per day</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Medication Allergies- Please list name of medication and type of reaction: _____

Other Allergies- Please list name and type of reaction: _____

Preventative Care

<u>Name of test</u>	<u>Date done</u>	<u>Results</u>	<u>Ordering Doctor</u>
Pap Smear	_____	_____	_____
Mammogram	_____	_____	_____
Prostate Blood Test	_____	_____	_____
Stool Cards	_____	_____	_____
Colonoscopy	_____	_____	_____
Pneumonia Vaccine	_____	_____	_____
Tetanus Vaccine	_____	_____	_____
Bone Density	_____	_____	_____