# ADULT HEALTH QUESTIONNAIRE

Name: Date of Birth:

## CURRENT HEALTH CONCERNS

| **Health Concern** | Current treatment? | Who is treating this? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| **Allergies** (drug/environmental/ food) | Symptoms |
|---|---|
| | |
| | |
| | |
| | |

| **Food Sensitivities** | Symptoms |
|---|---|
| | |
| | |
| | |
| | |

| **Current Medications** | Dose | Times/Day | Current Prescriber |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| **Current Herbs/Vitamins/Supplements** | Dose | Times/Day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

| **HEALTHCARE PROVIDERS** | Provider/Group Name | Last Seen (month/year) |
|---|---|---|
| Primary Care Practitioner | | |
| OB/GYN | | |
| Dentist | | |
| Eye Care | | |
| Other | | |

**Immunizations**

❒ Immunizations are ALL up to date ❒ Behind Schedule ❒ Never Immunized ❒ Unknown ❒ Unsure

States immunized in: ❒ VT ❒ NY ❒ NH ❒ MA ❒ CT ❒ Other

List childhood illnesses:

List prior illness, injury, hospitalization, surgery, and/or trauma (including dates):

(continued)

Name: Date of Birth:

| **HEALTH SCREENING HISTORY** | Date of most recent | HEALTH SCREENING (cont) | Date of most recent |
|---|---|---|---|
| Mammogram | | Professional Prostate Exam | |
| Pap Smear | | Colonoscopy | |
| Professional Breast Exam | | Lab Tests | |
| DEXA/Osteoporosis | | Imaging (Xray, CT, MRI)/Reason | |

## PERSONAL/FAMILY HISTORY

* MGM (Maternal Grandmother), MGF (Maternal Grandfather), PGM (Paternal Grandmother), PGF (Paternal Grandfather), Aunt(s), Uncle(s)

| | SELF | MOTHER | FATHER | SISTER(S) | BROTHER(S) | OTHER (please specify)* |
|---|---|---|---|---|---|---|
| **Birth Date** | | | | | | |
| **Age (age at death)** | | | | | | |
| Cause of death | | | | | | |
| | | | | | | |
| **Check those applicable:** | | | | | | |
| Alcoholism/Substance Abuse | | | | | | |
| Allergies/Hay Fever | | | | | | |
| Asthma | | | | | | |
| Anemia | | | | | | |
| Anxiety | | | | | | |
| Autism Spectrum Disorder | | | | | | |
| Bleeding Disorder | | | | | | |
| Cancer or Tumor (Specify Type) | | | | | | |
| Chronic Fatigue | | | | | | |
| Diabetes (Type 1 or Type 2) | | | | | | |
| Depression | | | | | | |
| Epilepsy | | | | | | |
| Glaucoma/Other Eye Disorder | | | | | | |
| Genetic Disease | | | | | | |
| Heart Disease | | | | | | |
| Hepatitis | | | | | | |
| High Blood Pressure | | | | | | |
| High Cholesterol | | | | | | |
| Kidney Disease | | | | | | |
| Mental Health Disorder | | | | | | |
| Rheumatism/Arthritis | | | | | | |
| Stomach Ulcer | | | | | | |
| Stroke | | | | | | |
| Thyroid Disorder | | | | | | |
| Tuberculosis | | | | | | |
| Other (specify) | | | | | | |

(continued)

Name: Date of Birth:

## HOUSING

Housing type: ❒ Single family home ❒ Apartment ❒ Condo ❒ Other: _____
❒ Children (list gender/ages): _____
Major stresses in last 12 months: ❒ Money ❒ Job ❒ Marriage ❒ Home Life ❒ Children ❒ Housing/Food Insecurity
❒ Other stressors _____
Rate your stress level 1 to 10 on average (10 worst stress): _____ Is this a change? ❒ Yes ❒ No

## DIET

Check which diet(s) you currently follow: ❒ Regular Diet ❒ Vegetarian ❒ Vegan ❒ Pescatarian ❒ Keto
❒ Low Carbohydrate ❒ High Protein ❒ FODMAP ❒ SIBO ❒ Other: _____

## EXERCISE

What type of exercise do you engage in currently? ❒ Aerobic ❒ Anaerobic ❒ Flexibility ❒ Weight Lifting ❒ None
Frequency of workout: ❒ Daily ❒ 4-6 times a week ❒ 2-3 times a week ❒ Weekly ❒ Monthly
Duration of session: ❒ <30 minutes ❒ 30-45 minutes ❒ 45-60 minutes ❒ 60-90 minutes ❒ 90+ minutes

## TOBACCO HISTORY

Are you a current smoker? ❒ Yes ❒ Never smoked ❒ Former smoker (when quit:___)
If yes, how many packs a day are you currently smoking? _____
How long have you been smoking for (in years)? _____
How many times have you tried to quit? ❒ 1 ❒ 2 ❒ 3 ❒ 4+

❒ Yes, cigarettes
❒ Yes, e-cigarettes
❒ Yes, vaping, juuling

## RECREATIONAL DRUG HISTORY

Have you ever used recreational drugs? ❒ Yes ❒ Never used ❒ Former user
Substance(s) used: ❒ Cannabis ❒ Cocaine ❒ Benzodiazepines ❒ Opioids ❒ Heroin ❒ Other _____

## ALCOHOL HISTORY

Do you drink alcohol? ❒ Yes ❒ Never drank ❒ Former drinker
How many glasses of wine per day? _____
How many glasses of beer per day? _____
How many hard spirits or shots per day? _____

## SLEEP HISTORY

Do you currently have sleep issues? ❒ Falling asleep ❒ Staying asleep ❒ Easy waking ❒ None of these
❒ Other (sleep walking, eating, night terrors, etc.) _____
How many hours of sleep on average do you get a night? _____ hours

## TRAVEL HISTORY

List all recent travel outside of the country: _____

## MEDICAL DEVICE HISTORY

Do You Use or Have Any of these Devices? ❒ Brace (Neck, Back) ❒ Pacemaker ❒ IUD ❒ Artificial Limbs
❒ Artificial Heart Valve ❒ Blood Vessel Stent ❒ Joint Replacement ❒ Other Metal Implants: _____
❒ Nexplanon (birth control implant)
❒ Name + Serial Number (if available) _____

(continued)

Name: Date of Birth:

## REVIEW OF SYSTEMS/HEALTH SCREENING HISTORY

Check the response that applies:

Y = current condition P = past condition N = a condition you've never had

| GENERAL | | When | |
|---|---|---|---|
| Weight | | Height | |
| Weight 1 yr ago | | Energy Level (1-10) | |
| Max Weight | | General Daily Pain (1-10) | |

| CONSTITUTIONAL | Y | P | N |
|---|---|---|---|
| Chills | | | |
| Decline in Health | | | |
| Fatigue | | | |
| Fever | | | |
| Weight Gain | | | |
| Weight Loss | | | |

| HEAD | Y | P | N |
|---|---|---|---|
| Headache | | | |
| Head Injury | | | |
| Migraines | | | |
| Dizziness | | | |

| EYES | Y | P | N |
|---|---|---|---|
| Impaired Vision | | | |
| Eye Pain | | | |
| Tearing | | | |
| Dryness | | | |
| Glaucoma | | | |
| Cataracts | | | |
| Light Sensitivity | | | |
| Itchy Eyes | | | |

| EARS | Y | P | N |
|---|---|---|---|
| Impaired Hearing | | | |
| Ringing | | | |
| Earache | | | |

| NOSE/SINUSES | Y | P | N |
|---|---|---|---|
| Nose Bleeds | | | |
| Stuffiness | | | |
| Runny Nose | | | |
| Sinus Problems | | | |

| MOUTH/THROAT | Y | P | N |
|---|---|---|---|
| Frequent Sore Throat | | | |
| Gum Disease | | | |
| Hoarseness | | | |
| Teeth Grinding | | | |
| Canker Sores | | | |

| NECK | Y | P | N |
|---|---|---|---|
| Lumps | | | |
| Swollen Glands | | | |
| Goiter | | | |
| Pain or Stiffness | | | |

| RESPIRATORY | Y | P | N |
|---|---|---|---|
| Cough | | | |
| Spitting up Blood | | | |
| Wheezing | | | |
| Asthma | | | |
| Bronchitis | | | |
| Pneumonia | | | |
| Emphysema | | | |
| Pain on Breathing | | | |
| Shortness of Breath | | | |
| At Night | | | |
| Lying Down | | | |

| CARDIOVASCULAR | Y | P | N |
|---|---|---|---|
| Heart Disease | | | |
| High Blood Pressure | | | |
| Murmurs | | | |
| Chest Pain | | | |
| Swelling of Ankles | | | |
| Palpitations, Fluttering | | | |

| GASTROINTESTINAL | Y | P | N |
|---|---|---|---|
| Heartburn | | | |
| Easy fullness | | | |
| Nausea | | | |
| Vomiting | | | |
| Bowel Movements | | | |
| How Often? | | | |
| Is This a Change? | | | |
| Diarrhea | | | |
| Constipation | | | |
| Blood in Stool | | | |
| Belching or Gas | | | |
| Bloating | | | |
| Stomach Pain | | | |
| Jaundice (yellow skin) | | | |
| Liver Disease | | | |
| Hemorrhoids | | | |

| MUSCULOSKELETAL | Y | P | N |
|---|---|---|---|
| Joint Pain or Stiffness | | | |
| Arthritis | | | |
| Broken Bones | | | |
| Muscle Pain | | | |
| Muscle Spasms or Cramps | | | |
| Restless Legs | | | |
| Chronic Low Back Pain | | | |
| Motor Vehicle Accident | | | |

| BEHAVIORAL | Y | P | N |
|---|---|---|---|
| Bulimia | | | |
| Anorexia | | | |
| Addiction | | | |
| To What? | | | |

| EMOTIONAL | Y | P | N |
|---|---|---|---|
| Depression | | | |
| Anger | | | |
| Anxiety or Nervousness | | | |
| Trauma History | | | |

| SKIN | Y | P | N |
|---|---|---|---|
| Rashes | | | |
| Eczema | | | |
| Psoriasis | | | |
| Acne, Boils | | | |
| Itching | | | |
| Color Change | | | |
| Lumps | | | |
| Night Sweats | | | |
| Nails breaking | | | |
| Warts | | | |
| Fungal Infections | | | |

| NEUROLOGIC | Y | P | N |
|---|---|---|---|
| Fainting | | | |
| Seizures | | | |
| Paralysis | | | |
| Muscle Weakness | | | |
| Numbness or Tingling | | | |
| Loss of Memory | | | |
| Brain Fog | | | |
| Word Retrieval Problems | | | |
| Tremor | | | |

| ENDOCRINE | Y | P | N |
|---|---|---|---|
| Diabetes (Type 1 or 2) | | | |
| Hypothyroid/Hyperthyroid | | | |
| Heat or Cold Intolerance | | | |
| Excessive Thirst | | | |
| Excessive Hunger | | | |
| Binge Eating | | | |
| Change in Libido | | | |
| Night Sweats | | | |

| BLOOD | Y | P | N |
|---|---|---|---|
| Anemia | | | |
| Bleeding | | | |
| Bruising | | | |

| IMMUNE SYSTEM | Y | P | N |
|---|---|---|---|
| Epstein Barr | | | |
| Mono | | | |
| Shingles | | | |
| CMV | | | |
| Lupus | | | |
| Crohn's | | | |
| Chronic Infections | | | |
| Lyme | | | |
| Mold Exposure | | | |

| URINARY | Y | P | N |
|---|---|---|---|
| Pain with Urination | | | |
| Increased Frequency | | | |
| Inability to Hold Urine | | | |
| Frequent Infections | | | |
| Kidney Stones | | | |

| PERIPHERAL VASCULAR | Y | P | N |
|---|---|---|---|
| Deep Leg Pain | | | |
| Cold Hands/Feet | | | |
| Varicose Veins | | | |

(continued)

## FEMALE/MALE MEDICAL HISTORY — AND SEXUAL HISTORY

Name: Date of Birth:

Check the response that applies: Y = current condition P = past condition N = a condition you've never had

### FEMALE MEDICAL HISTORY

| MENTRUAL HEALTH | | | |
|---|---|---|---|
| Age Menses Began | | | |
| Average Number of Days | | | |
| Length of Cycle | | | |
| | Y | P | N |
| Bleeding Between Periods | | | |
| Regular Cycles | | | |
| Extended Time Without Menses | | | |
| How Long? | | | |
| Pain During Intercourse | | | |
| Vaginal Dryness | | | |
| Vaginal Itchiness | | | |
| Yeast Infections | | | |
| Painful Menses | | | |
| Bacterial Vaginosis | | | |
| Endometriosis | | | |
| PCOS (Polycystic Ovary Syndrome) | | | |
| Excessive Flow | | | |
| Excessive Facial Hair | | | |
| Excessive Body Hair | | | |

| MENOPAUSE | Y | P | N |
|---|---|---|---|
| Menopausal Symptoms | | | |
| Describe: | | | |
| | | | |
| Age They Began | | | |
| Age of Your Mother at Menopause | | | |

| BREAST HEALTH | Y | P | N |
|---|---|---|---|
| Do You Perform Self Exam | | | |
| Breast Lumps | | | |
| Breast Pain or Tenderness | | | |
| Nipple Discharge | | | |

| OBSTRETICS | Y | P | N |
|---|---|---|---|
| Birth Control | | | |
| What Type? | | | |
| Number of Pregnancies | | | |
| Number of Live Births | | | |
| Number of Miscarriages | | | |
| Number of Abortions | | | |
| Difficulty Conceiving | | | |

### MALE MEDICAL HISTORY

| | Y | P | N |
|---|---|---|---|
| Hernias | | | |
| Testicular Masses | | | |
| Testicular Pain | | | |
| Prostate Problems | | | |
| Discharge or Sores | | | |
| Trouble Starting & Stopping Stream | | | |
| Erectile Disfunction | | | |
| Premature Ejaculation | | | |
| **URINE RETENTION** | **Y** | **P** | **N** |
| Scrotal Mass | | | |
| Scrotal Pain | | | |

### SEXUAL HISTORY

Gender ❒ Female ❒ Male ❒ Female-to-Male
❒ Male-to-Female ❒ Nonbinary ❒ Other

Sexual Orientation Identity
❒ Bisexual ❒ Gay ❒ Heterosexual ❒ Lesbian ❒ Queer
❒ Not sure/Don't know ❒ Asexual ❒ Other

Are You Sexually Active? ❒ Yes ❒ No

Sexual Difficulties:

I have been diagnosed with and/or treated for:
❒ Bacterial Vaginosis ❒ Chlamydia ❒ Gonorrhea
❒ Herpes ❒ HPV ❒ Syphilis ❒ Trich ❒ Other:

You have been tested for HIV in the past? ❒ Yes ❒ No

Are you HIV-positive? ❒ Yes ❒ No ❒ Unknown

You have ever been diagnosed with or tested for the following?
❒ Hepatitis A ❒ Hepatitis B ❒ Hepatitis C

List additional health history which may be pertinent.

I certify that information supplied is correct to the best of my knowledge.

Printed Name _____ Date _____

Signature _____ Relationship to Patient: _____