1919 Lathrop St. Suite 222
Fairbanks, AK 99701

Adult Health History Questionnaire

Your answers on this form will help us understand your medical concerns and conditions.
ALL QUESTIONS ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Full Legal Name: _____ Today's Date: _____

Preferred Name: _____ Pronouns: _____ Date of Birth: _____

Sex Assigned at Birth: ☐ Female ☐ Male ☐ Intersex

What are you hoping to address during today's appointment?

_____

MEDICAL HISTORY

List Medication Allergies or Reactions: **If no allergies check ☐ NONE**

Medication Allergy	Reaction
1.	
2.	
3.	

Please check to indicate if you have ever had the following conditions:

☐ Anxiety Disorder	☐ Emphysema	☐ Obesity
☐ Arthritis	☐ Eye Problems, Type: _____	☐ Pulmonary Embolism
☐ Asthma	☐ Fibromyalgia	☐ Reflux or ☐ Ulcers
☐ Allergies or Hay fever	☐ Gout	☐ Seizures
☐ Anemia	☐ Headaches or ☐ Migraines	☐ Sexually Transmitted Infections
☐ Bleeding Disorder	☐ Heart Attack	☐ Skin Disease or Chronic Rashes
☐ Blood Clots/DVT	☐ Heart Murmur	☐ Stroke
☐ Cardiac Arrhythmia or Pacemaker	☐ HIV or AIDs	☐ Substance Use Disorder
☐ Congestive Heart Failure	☐ High Cholesterol	☐ Thyroid Disease
☐ Coronary Artery Disease	☐ High Blood Pressure	☐ Tuberculosis
☐ Depression	☐ Insomnia	☐ Unhealthy Alcohol Use
☐ Diabetes	☐ Kidney Disease	☐ Cancer, Type:
☐ Dialysis	☐ Kidney Stones	
☐ Diverticulitis	☐ Liver Disease or Hepatitis	☐ Other, Please Explain:
☐ Eating Disorder	☐ Osteoporosis	

Please list any surgeries or overnight hospital stays:

Type of surgery/reason for hospitalization	Reason	Date or Approx Year
1.		
2.		
3.		

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If you have any other medical problems or serious injuries that are not listed previously, please describe them here:

_____

_____

_____

List all medications you are currently taking.
Include vitamins, supplements, and medications; including prescriptions, inhalers, and over-the-counter drugs.

Medication Name	Strength	Frequency Taken
1.		
2.		
3.		
4.		
5.		

Preferred Pharmacy: _____

Are you receiving care from any other doctors, chiropractors, or other health professionals?

Provider's Name & Title	Condition they are treating you for
1.	
2.	
3.	

FAMILY HISTORY

Check any diseases that run in your family:

	Mother	Father	Sister	Brother	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Other
Alcoholism									
Arthritis									
Depression									
Diabetes									
Cancer *type: _____									
Genetic Disease									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Obesity									
Stroke									
Thyroid Disease									

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HEALTH HABITS

Do you exercise? ☐ Yes ☐ No
If yes, What kind/how often _____

Do you smoke, vape, or use any tobacco/nicotine products? ☐ Yes ☐ No ☐ Quit
Number of cigarettes each day? _____ For how many years? _____ Other forms of nicotine? _____

Do you use marijuana or THC products? ☐ Yes ☐ No ☐ Quit How much? _____ How often? _____

Do you regularly use other drugs? ☐ Yes ☐ No ☐ Quit Type of other drugs _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit

PERSONAL HISTORY

Are you currently married, living with a partner, or living with a significant other? ☐ Yes ☐ No
If yes, Who lives with you at home? _____

Are you employed? ☐ Yes ☐ No ☐ Retired
If yes, What kind of work do you do?_____

SEXUAL HISTORY

Are you sexually active? ☐ Yes ☐ No
If yes, With: ☐ Men ☐ Women ☐ Both, Do you have: ☐ Oral ☐ Vaginal ☐ Anal Sex

Are you interested in STD testing? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No How many children do you have? ____

Do you *or your partner* use any form of birth control? ☐ Yes ☐ No
If yes, Which type? _____

OB AND MENSTRUAL HISTORY

Have you ever been pregnant? ☐ Yes ☐ No
If yes, How many times? _____ How many miscarriages? _____ How many abortions? _____
How many living children? _____

Do you have menstrual periods? ☐ Yes ☐ No
If yes, First day of last period _____ Are your periods regular? ☐ Yes ☐ No # of days between periods _____
If no, At what age did they stop? _____