ADULT HEALTH 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.

PATIENT NAME: _____

PREFERRED NAME: _____ PRONOUNS: _____

PATIENT DATE OF BIRTH: _____ TODAY'S DATE: _____

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.		

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	Grandmother (maternal)	Grandfather (maternal)	Grandmother (paternal)	Grandfather (paternal)	Other
Alcoholism									
Arthritis									
Depression									
Diabetes									
Cancer *type: _____									
Genetic Disease									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Obesity									
Stroke									
Thyroid Disease									

HEALTH HABITS

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

Do you smoke or use any tobacco products? ☐ Yes ☐ No ☐ Quit
Number of cigarettes each day? ____ For how many years? _____Other forms of tobacco? _____

Do you use marijuana? ☐ 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 or living with a partner or significant other? ☐ Yes ☐ No

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 With: ☐ Men ☐ Women ☐ Both

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
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? _____