ADULT HEALTH QUESTIONNAIRE—BASIC HEALTH HISTORY

NAME_____ DOB____/____/____ DATE____/____/____

Marital Status: (check one) Single ☐ Married ☐ Widowed ☐ Domestic Partner ☐

CURRENT HEALTH SUMMARY

Health Habits, Life Changes	Yes	No
Do you smoke cigarettes?	____	____
How many per day?_____		
How long have you smoked?_____		
Do you drink alcohol?	____	____
Have you ever:		
Felt the need to cut down on drinking?	____	____
Felt annoyed by criticism of drinking?	____	____
Had guilty feelings about drinking?	____	____
Taken a morning eye opener?	____	____

Work Exposure:
Are you or were you exposed to hazards at home, at work or Due to your hobbies? (e.g. biological hazards, asbestos, chemicals Solvents, dust, fumes, heavy metals (e.g. lead or mercury), excessive Noise, radiation, high stress or extremes of temperature. Which ones?

_____

_____

Have you had a tetnaus booster in the past ten years? Yes ☐ No ☐
Have you had a pnuemovax in the past ten years? Yes ☐ No ☐

PERSONAL HEALTH

Have you had any of the following	Yes	No
Arthritis	____	____
Asthma	____	____
Diabetes	____	____
Heart disease	____	____
Seizures (epilepsy)	____	____
High blood pressure	____	____
Depression	____	____
Cancer	____	____
Positive TB skin test	____	____
Tuberculosis	____	____
High Cholesterol	____	____
Blood Transfusion	____	____
Thyroid Condition	____	____
Hepatitis (jaundice)	____	____
Sexually transmitted disease	____	____
Glaucoma	____	____
Cataracts	____	____

Other illness: (please describe)

_____

_____

_____

Advanced Directives:
Do you currently have a living will? Yes ☐ No ☐ Are you interested in establishing a living will? Yes ☐ No ☐

Past Medical History:

_____
_____
_____
_____
_____
_____
_____

Past Surgical History:

_____
_____
_____
_____
_____
_____
_____

Current Medications;

Name of Medication	Dose and How Often	What do you take it for?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any ***non-prescription*** medications you take (such as- aspirin, vitamins, laxatives, etc)

_____

List any medications you are allergic to: _____

_____

Family Health:
Is your mother living? Yes No
Is your father living? Yes No
How many brothers do you have? _____
How many sisters do you have? _____

Age now or at death
Mother _____
Father _____

Do you have an advance directive? Yes No

Illness in Family

Mother: _____
Father: _____
Brothers or Sisters _____

Has any family member had:	Yes	No	Who (Parents, siblings, aunts, uncles, grandparents)
Tuberculosis	___	___	_____
Diabetes	___	___	_____
High Cholesterol	___	___	_____
Heart Attack	___	___	_____
Breast Cancer	___	___	_____
Other Cancer	___	___	_____
High Blood Pressure	___	___	_____
Stroke	___	___	_____
Depression	___	___	_____
Sickle Cell Anemia	___	___	_____

Name any conditions that run in your family: _____
_____

For Children: 12mos-12yrs

Has your child had a recent well child exam? Yes No

Are immunizations up to date? Yes No

Has your child had chicken pox? Yes No

Does your child use a car seat/seatbelt? Yes No

Does your child wear a helmet while biking or rollerblading? Yes No

Teenagers 13-17

Has your teenager had a recent physical exam? Yes No

Has your teenager had a recent tetanus shot? Yes No

Do you have any concerns regarding the following:

nutrition/weight control depression drugs/alcohol

abstinence/sex education sleep habits smoking

Has your child/teenager had a problem with the following? If yes, please explain

Vision or hearing	Yes	No	_____
Frequent ear infections	Yes	No	_____
Asthma	Yes	No	_____
Pnuemonia/Bronchitis	Yes	No	_____
Hay Fever	Yes	No	_____
Seizures	Yes	No	_____
Kidney/bladder infection	Yes	No	_____
Development	Yes	No	_____
Feeding/eating	Yes	No	_____
Behavior	Yes	No	_____
Tobacco use/exposure	Yes	No	_____

Other health problems: _____
_____