ADULT Health History Questionnaire Name:_____

Surgical History

Surgery	Date	Place

Past Medical History *(check those that apply)*

____ Diabetes Type 2	____IV Drug Use	____Diabetes Type 1
____Hypertension	____Prescription Med Abuse	____Glaucoma
____Hyperlipidemia	____Coronary Artery Disease	____Heart Attack
____Hypothyroidism	____Seizures	____Hepatitis B
____Cancer (specify)		____Hepatitis C
____Bipolar Disorder	____Stroke	____PVD
____Depression	____Allergic Rhinitis	____Suicide Attempt
____Anxiety	____Anemia	____Sexually Transmitted Disease
____Alcohol Abuse	____Asthma	____Other (specify)

MedicationAllergies *(please list medication and reaction)*		

Social History *(please circle or write your answers)*

Occupation	
Education	8 9 10 11 grad. high school 2 year college college grad
Marital Status	Single Married Separated Divorced Widowed

Exercise Level	None Occasional Moderate Heavy
Diet	Regular Vegetarian Vegan Other (specify)
General stress level	Low Medium high
Smoking	Yes No How much per day?
Have smoked since age?	
Alcohol Intake	None Occasional Moderate Heavy
Caffeine Intake	None Occasional Moderate Heavy
Chewing Tobacco	Yes No How many times per day?
Illicit Drugs	Yes No
Guns present in the home	No
Seat belts used routinely	Yes No
Sunscreen used routinely	Yes No
Smoke alarm in home	Yes No
Advance directives	Yes No
Tobacco Years of use	

Alcohol Years of use	
Sexually active?	Yes No

Family History

Family Member Parent, grandparents, etc….	Illness	Age at death (if deceased)

Specialty Physician(s) that you currently see for medical care		
Name	Specialty	Phone #
MEDICATIONS *(new patients only)*		
Durable Medical Equipment please list all you currently use – i.e., wheelchair, walker, oxygen, Cpap, etc….)		Where do you get your DME from?

Mountain View MEDICAL

Review of Systems Date:_____ Name _____

In the last **six months** have you had a problem with:

Skin

Your skin? Y / N

Endocrine

Excessive fatigue? Y / N Night sweats? Y / N Excessive thirst? Y / N

GI

Frequent heartburn? Y / N Frequent indigestion? Y / N Abdominal pain? Y / N Abdominal cramps? Y / N Constipation? Y / N Bloody bowel movements? Y / N Black/tarry bowel movements? Y / N Nausea or vomiting? Y / N Eating? Y / N Swallowing? Y / N

Cardio

Dizziness? Y / N Lightheadedness? Y / N A thumping heart? Y / N A racing heart? Y / N Chest Pains? Y / N Tightness across the chest? Y / N Unusual bruising? Y / N

How many times have you fallen?_____

Do you have any other concerns that you would like to share with the provider?

_____
_
_____
_
_____
_

Pulmonology

Shortness of breath? Y / N Coughing? Y / N

ENT

Seeing? Y / N Hearing? Y / N Smelling? Y / N Lumps in neck? Y / N

Musculoskeletal

Arthritis? Y / N Back Pain? Y / N Swollen feet or ankles? Y / N Fluid retention in legs? Y / N

Urinary

Frequent or painful urination? Y / N
Uncontrolled leaking of urine? Y / N

Constitutional?

Sleeping? Y / N Fever? Y / N Chills? Y / N Weight loss or gain? Y / N

Neurological

Frequent headaches? Y / N Numbness or tingling? Y / N