Family Care Health Centers
Adult Medicine Questionnaire

Date: _____ Patient Name: _____ Date of Birth: _____ Age: ____ Address: _____ Phone#: (H) _____ Work#: _____
Prior Physician(s): _____
Marital Status: □ Single □Married □ Divorced □ Separated □Widow/er □Religion (optional):_____
Social Security No.:_____ Maiden Name (if applicable): _____
Employer's Name: _____ Occupation: _____
Employer's Address: _____
Spouse's Phone#: H) _____ Emergency Contact Name: _____
W) _____ Relationship: _____ Phone: _____

FAMILY HISTORY

MOTHER
Is your mother alive? □Yes □No How old is she? _____
If deceased, what age and what did she die from? _____
Does/did she have serious health problems during life? _____

FATHER
Is your father alive? □Yes □No How old is he? _____
If deceased, what age and what did he die from? _____
Does/did he have serious health problems during life? _____

IS THERE A HISTORY IN YOUR FAMILY OF?

□Diabetes
□High Blood Pressure
□Bleeding Disorders
□Ulcerative or Crohn's Disease
□Premature Heart Attack or Bypass (Before age 55)
□Breast Cancer
□Migraine Headaches
□Asthma or Allergies
□Sickle Cell Anemia
□Colon Cancer
□Ovarian Cancer
□Prostate Cancer

MEDICAL HISTORY

List ongoing chronic medical problems _____
_____

List any and all surgeries or hospitalizations you have had with approximate dates: _____
_____

List all medications (with dosage and frequency) you take (include Tylenol, Aspirin, Birth Control Pills etc.)
_____

List any medications you are allergic to: _____

Date of:
Last Tetanus Booster Injection: _____ Last MMR: _____
Last Tuberculosis Skin Testing: _____ Response: □Positive □Negative
Last Pneumovax Injection: _____ Other Adult Vaccinations: _____

HAVE YOU EVER HAD THE FOLLOWING?

□Measles
□Chicken Pox
□Mono
□Rheumatic Fever
□A heart murmur
□An irregular pulse
□A fainting spell
□Diabetes
□High blood pressure
□Anemia
□Asthma
□Pneumonia
□A concussion
□A seizure (Epilepsy)
□An ulcer
□A psychiatric problem
□Sickle cell anemia
□A blood transfusion
□Hepatitis
□High Cholesterol
□Radiation treatment to tonsils or adenoids
□A Kidney Stone
□Exposure to Toxic chemicals, asbestos or silicon dust
□Household exposure to person with tuberculosis
□Easy bleeding
□Cancer
□HIV/Aids

PERSONAL HISTORY

Physical Condition:

Do you exercise regularly? □Yes □No If Yes, doing what? _____
Current Weight_____ Weight 2 years ago? _____

Tobacco:

Do you smoke or chew tobacco? □Yes □No Have you ever smoked? □Yes □No
# of Packs per Day_____ Age at which started: _____Year you quit smoking: _____

Alcohol:

Have you ever felt you ought to cut down on your drinking? □Yes □No
Have people annoyed you by criticizing your drinking? □Yes □No
Have you felt bad or guilty about your drinking? □Yes □No
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover/eye opener? □Yes □No

Drugs:

Do you smoke marijuana? □Yes □No Use illicit drugs? □Yes □No

Sexual:

Have you ever had a sexually transmitted disease? □Yes □No
Sexual Preference: □Heterosexual (straight) □Homosexual (gay)

Woman Only:

Age of first period: _____ Are periods: □Regular □Heavy □Painful Date of last Pap Smear: _____
Have you ever had an abnormal pap smear? □Yes □No Method of birth control: _____
Date of onset menopause: _____ Date of last Mammogram: _____
Do you perform self-breast exam? □Yes □No

DO YOU <u>CURRENTLY</u> HAVE PROBLEMS WITH?

□Severe Headaches	□Shortness of Breath	□Severe Indigestion/Heartburn	□Back Pain
□Abdominal Pain	□Heart Palpitations	□Diarrhea	□Arthritis
□Recurrent Nosebleeds	□Depression	□Constipation	□Skin Rashes
□Ringing in Ears	□Insomnia	□Pains in legs while walking/rest	□Hives
□Dizziness	□Nervousness or Anxiety	□Black, Tar-like Stools	□Chest Pains
□Difficulty Swallowing	□Chronic Cough	□Frequent Urination	□Wheezing
□Phlebitis/Blood Clots	□Ankle Swelling	□Coughing Up Blood	□Blood in Stool
□Blood in Urine	□Painful (Burning) Urination		

Do you wear glasses □Yes □No How is your eyesight (with glasses)? _____
Date of last eye exam? _____ How is your hearing? _____
How many pillows do you sleep on? _____ Do you wake up at night short of breath? □Yes □No
Do you wake up at night to urinate? □Yes □No If Yes, how often? _____

_____ _____
Patient Signature **Date**

_____ _____
Provider Signature **Review Date(s)**