Initial Adult History Questionnaire

Today's Date: _____ Patient Name: _____Preferred Name_____ DOB: _____

Gender from Birth_____Gender Identity _____ NonBinary?_____ How did you hear about us? _____

Please list specialists you are seeing (including Gyne): _____

_____

Reason for today's visit: _____

Do you have a medical advance directive or a living will? ❒ Yes ❒ No (If yes, please provide our office with a copy.)

Do you need any of the following: (Please circle)

Disability Paperwork Return to work note Surgical Clearance Prescription Refills Beside Commode Rolling Walker Cane

Are you interested in any of the following? (Please Circle) PrEP - HIV Prevention HIV Screening Hepatitis C Screening STD Screening

Weight Loss Diabetes Screening Preventing / Planning Pregnancy Cervical Cancer Vaccine Shingles Vaccine Flu Vaccine

Past Medical History

Abnormal Heart Rhythm	❒Currently ❒ Past	Heart Attack or blockages	❒Currently ❒ Past
Acid Reflux	❒Currently ❒ Past	High Blood Pressure	❒Currently ❒ Past
Allergies/ Sinus Trouble	❒Currently ❒ Past	High Cholesterol	❒Currently ❒ Past
Anemia	❒Currently ❒ Past	HIV	❒Currently ❒ Past
Anxiety	❒Currently ❒ Past	Joint Pain (specify)_____	❒Currently ❒ Past
Asthma	❒Currently ❒ Past	Kidney Disease	❒Currently ❒ Past
Back Pain	❒Currently ❒ Past	Liver Disease	❒Currently ❒ Past
Bipolar Disorder	❒Currently ❒ Past	Lupus	❒Currently ❒ Past
Cancer Specify: _____	❒Currently ❒ Past	Neuropathy	❒Currently ❒ Past
Congestive Heart Failure	❒Currently ❒ Past	Sarcoidosis	❒Currently ❒ Past
Depression	❒Currently ❒ Past	Stomach Ulcers	❒Currently ❒ Past
Diabetes	❒Currently ❒ Past	Stroke	❒Currently ❒ Past
Emphysema	❒Currently ❒ Past	_____	❒Currently ❒ Past
Fibromyalgia	❒Currently ❒ Past	_____	❒Currently ❒ Past

Family History

Please use the following key: MGM- Maternal Grandmother, PGM- Paternal Grandmother, MGF- Maternal Grandfather, PGF- Paternal Grandfather, M-Mother, F-Father, A- Aunt , U- Uncle, B-Brother, S- Sister, C- Cousin

Heart attack	❒Yes ❒No	Who_____	Comments _____	
Congestive Heart Failure	❒Yes ❒No	Who_____	Comments _____	
Diabetes	❒Yes ❒No	Who_____	Comments _____	
Dialysis for Kidney Disease	❒Yes ❒No	Who_____	Comments _____	
Cancer, (Type): _____	❒Yes ❒No	Who_____	Comments _____	
Hypertension	❒Yes ❒No	Who_____	Comments _____	

Additional Family History: _____

_____

_____

Social History

What is your occupation? _____

Sexual Partner Preference: Males ❒ Females ❒ Both ❒ Have a significant other? ❒ Yes ❒ No Marital Status: _____

Do you have any children? ❒ Yes ❒ No If yes, how many? _____

Have you ever used tobacco? ❒ Currently ❒ Formerly ❒ Occasionally ❒ Never If yes: Packs per day_____ How many years? _____

Do you drink alcohol? ❒ Currently ❒ Formerly ❒ Occasionally ❒ Never

If yes, what do you drink? _____ How much? _____ How often? _____

Have you ever done drugs? ❒ Currently ❒ Formerly ❒ Occasionally ❒ Never If yes, which? _____

Reproductive History (Women Only)

Do you have regular monthly periods? ❒ Yes ❒ No
Number of days in cycle? _____
Heavy Bleeding? ❒ Yes ❒ No
Painful? ❒ Yes ❒ No
What age did you start having periods? _____
What age did you stop having periods? _____ Reason: _____
Have you ever been pregnant? ❒ Yes ❒ No Number of pregnancies _____Number of Children_____Complications _____

Past Surgical History

Please check any surgeries you have had:

❒ Amputation , Please specify: _____ Date: _____
❒ Appendix Removed Date: _____
❒ Back Surgery Please specify: _____ Date: _____
❒ Gallbladder Removed Date:_____
❒ Heart Bypass/ Stent Date: _____
❒ Hysterectomy - ❒ Partial or ❒ Total Reason? _____ Date: _____
❒ Mastectomy Date: _____
❒ Tonsillectomy Date: _____

Please list any other surgeries with details:

_____
_____

Medication

Name of Medication	Dose	Number of times per day	Name of Medication	Dose	Number of times per day

Medication Allergies- Please list name of medication and type of reaction: _____

_____

Other Allergies- Please list name and type of reaction:_____

_____

Preventative Care

Name of test	Date done	Results	Ordering Doctor
Pap Smear	_____	_____	_____
Mammogram	_____	_____	_____
Prostate Blood Test	_____	_____	_____
Stool Cards	_____	_____	_____
Colonoscopy	_____	_____	_____
Pneumonia Vaccine	_____	_____	_____
Tetanus Vaccine	_____	_____	_____
Bone Density	_____	_____	_____