

**ADULT HEALTH QUESTIONNAIRE**  
**PLEASE COMPLETE BOTH PAGES OF FORM**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Your insurance company requires the following information for proper payment. Please fill out completely.

**REASON FOR TODAY'S VISIT:** \_\_\_\_\_

- 1) **Timing of problem**- continuous or intermittent (comes and goes)
- 2) **Quality of problem**-sharp, dull, irritating, burning, throbbing or (other) \_\_\_\_\_
- 3) **Duration of symptoms\ problems** \_\_\_\_\_ days/weeks/months/years
- 4) **Severity of symptoms/problems**- mild, moderate, severe
- 5) **Modifying factors**  
Things that make it worse: \_\_\_\_\_  
Things that make it better: \_\_\_\_\_
- 6) **Symptoms:** \_\_\_\_\_
- 7) **Previous Treatment**- Have you tried Medications for these symptoms? YES/ NO  
If yes, what medications: \_\_\_\_\_  
Other form of therapy / treatment: \_\_\_\_\_
- 8.) Have you had any x-rays, CAT scans, MRI, or lab work done in the last year related to current illness /problem?  
Yes / No  
When and Where: \_\_\_\_\_

**PAST MEDICAL HISTORY**- please circle or list your medical conditions / problems below

Alcoholism	Bleeding problems (type) _____	Heart Failure
Allergies (hay fever)	Cancer (type) _____	High blood pressure
Anemia	Diabetes	Kidney problems (type) _____
Angina/heart attack	Emphysema /COPD	Liver problems (type) _____
Arthritis	Epilepsy / Seizure Disorder	Lung problems (type) _____
Asthma	Glaucoma	Stroke
Birth Defects	Headaches	Thyroid Disorder (type) _____
Bladder Disease	Hearing loss	Tuberculosis
Other _____		

**MEDICATIONS**

Please list medication and dosage: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATION ALLERGIES:** YES or NO    **ENVIRONMENTAL ALLERGIES:** YES or NO

**LATEX ALLERGY:** YES or NO

If yes, please list and describe reaction:

\_\_\_\_\_  
\_\_\_\_\_

**PAST SURGICAL HISTORY**

Please list past surgeries/operations and when they occurred.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY**- Do any immediate family members have the following health problems?

If yes, please circle and state the relationship to you.

Anesthesia complications	Asthma	Bleeding problems	Cancer (type) _____		
Diabetes	Hearing loss	Heart Disease	Seizures	Stroke	Thyroid disorders

**SOCIAL HISTORY-** (please circle response)

Married/Partner      Single      Divorced/Separated      Widowed

Household Members: \_\_\_\_\_

Care Giver or Guardian Information: N/A or Yes \_\_\_\_\_

Occupation: \_\_\_\_\_ Retired? Previous Occupation: \_\_\_\_\_

Military Exposure Yes or No. If yes, which branch and when served: \_\_\_\_\_

- 1) Do you drink alcohol? Yes or No  
If yes, how often and # of drinks \_\_\_\_\_ per day/week/month
- 2) Do you smoke? Yes or No  
If yes, how many packs \_\_\_\_\_ per day/week/months. How many years \_\_\_\_\_
- 3) Have you smoked in the past? Yes or No. If yes when did you quit? \_\_\_\_\_
- 4) Does anyone smoke in the household? Yes or No
- 5) Do you chew tobacco, smoke pipes/cigars? Yes or No  
If yes, How much and how often? \_\_\_\_\_
- 6) Do you use recreational drugs? Yes or No If yes, \_\_\_\_\_
- 7) Do you have pets in the home? Yes or No If yes, type of animal \_\_\_\_\_
- 8) Do you exercise regularly? Yes or No If yes, type of exercise \_\_\_\_\_

**REVIEW OF SYSTEMS-**

Have you experienced any of the following within the last 6 months? Please circle the appropriate symptoms.  
(Chronic-present for more than 6 weeks)

**EARS**

Hearing loss  
Dizzy spells  
Pain in ears  
Ringing in the ears  
Drainage from ears  
Ear pressure

**NOSE**

Hay-fever  
Snoring  
Runny nose-chronic  
Excessive daytime sleepiness  
Loss of smell/taste  
Nosebleeds  
Postnasal drip-chronic

**THROAT**

Sore throat-Chronic  
Swallowing problems  
Heartburn  
Cough-chronic  
Hoarseness

**GENERAL**

Fever  
Chills  
Weight change  
Fatigue  
Night sweats  
Easy bruising/bleeding

**SKIN**

Rashes  
Sores  
Moles  
Lumps

**NEURO/PSYCH**

Memory loss  
Seizures  
Muscle weakness  
Anxiety  
Depression

**EYES**

Vision Change  
Tearing  
Corrective lenses  
(glasses/contacts)

**HEART**

Chest pain  
Previous heart surgery  
Palpitations/irregular heart beat

**LUNGS**

Shortness of breath  
Wheezing  
Using oxygen at home  
Asthma  
Emphysema

**GI**

Persistent nausea/vomiting  
Bloody stools  
Indigestion/heartburn

**MUSCLE/JOINT**

Joint pain  
Lack of coordination  
Arthritis

**ENDOCRINE**

Diabetes  
Thyroid: LOW/HIGH  
Thyroid problems

Any other health concerns or questions you would like to discuss during your visit: \_\_\_\_\_

\_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_