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Adult Health Questionnaire

Patient Name: _____

Date of Birth: _____

Health Plan: _____

I. What symptoms, medical problems and concerns have prompted this visit today?

II. What expectations do you have and what goals do you hope to accomplish by the conclusion of this office visit?

1. Please list any conditions or chronic illnesses you have (such as high blood pressure, diabetes, etc.):

None

2. Please list allergies to food or medications:

None

3. Please list all surgeries including the approximate date or age each was performed:

None

4. Do you presently smoke cigarettes? If you no longer smoke, when did you quit?
If still smoking, how much do you smoke?
5. How much alcohol do you consume in a week?
6. Do you have a history of alcoholism or chemical dependency?
7. When did you have your last complete physical examination or checkup?
8. When did you have your last tetanus shot?
9. Have you ever had a sigmoidoscopy (a screening test for colon polyps and tumors)? If so, when?
10. Have you ever had a total colonoscopy?
11. When did you have your last mammogram?
12. Have you ever had the Pneumovax or pneumonia vaccine?
13. If you are a diabetic, when did you have your last eye examination?
14. Have you ever had a bone mineral density (osteoporosis) test?
15. If so, when?
16. Have you ever had a treadmill test / cardiac exercise test to screen for coronary artery disease?
17. Have you filled out a so-called "advance directive"?
18. Have you been given information about motor vehicle accident injury prevention?
19. Is there any other information you feel we should know concerning your past health?
20. If so, please elaborate.
21. Is there family history of colon cancer, breast cancer, ovarian cancer or early onset heart attacks and coronary disease in the family? If so, indicate YES and discuss with the provider.
22. Do you have a personal problem you wish to discuss with the physician?

Signature

Date