ADULT HEALTH QUESTIONAIRE

Date: _____

Please print, complete, and bring to your initial appointment.		
Name:	Date of Birth:	M/ F (circle one)
Prior Physician:	Referred By:	
Current Concerns:		

Have you had these vaccines?

Check		Date?	Check		Date?
☐	Tetanus		☐	Pneumonia	
☐	Hepatitis A		☐	Chicken Pox/ Shingles	
☐	Hepatitis B		☐	Influenza (flu)	
☐	HPV		☐	Pertussis (Tdap)	

List all medications (specify amount and doses per day) including vitamins and over-the-counter:

Name of Drug	Strength	How Often Taken

Medical History:

List all known medical problems:

List any allergies to medications:

Name of Drug	Reaction it Causes

Surgical History:	Year	Reason

Hospitalization:	Year	Reason

Family Medical History: Indicate health problems

_____ _____

Signature Date

ADULT HEALTH QUESTIONAIRE

Date: _____

MEMBER	CURRENT AGE	AGE OF DEATH	HEALTH PROBLEMS
Mother			
Father			
Brother/Sister			
Brother/Sister			
Brother/ Sister			
Children			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Other			

HEALTH HABITS : Indicate all that apply

Lives with: _____

Sexually Active: ☐ Not Active ☐ Monogamous ☐ Multiple Partners Contraception type _____

Caffeine: _____ cups/cans per day

Tobacco/Smokeless tobacco: ☐ Never ☐ Currently ☐ Smoked from/to_____ ____ packs per day

Seatbelt Use: ☐ Yes ☐ No

Firearms in Home: ☐ Yes ☐ No Secured: ☐ Yes ☐ No

Alcohol: ☐ None Type _____ _____ per day _____ per week _____ per month

Street Drugs: ☐ Never ☐ Occasionally ☐ In Past ☐ Injection Use Type: _____

Exercise: ☐ Yes ☐ No Type: _____ How Often: _____

Diet: ☐ Regular ☐ Fast Foods ☐ Diabetic ☐ Low Fat ☐ Low Salt ☐ Vegetarian

Occupation: _____

Other information you think we should know that might affect your health:

Do you have an Advance Directive and/or Living Will? ☐ Yes ☐ No

Would you like assistance preparing these documents? ☐ Yes ☐ No

Physical and/or mental abuse is a major public health issue; this often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?
Yes ☐ No ☐

_____ _____

Signature Date