



ADULT HISTORY & QUESTIONNAIRE
CONFIDENTIAL

Date: _____

Patient's Name: _____
LAST FIRST MIDDLE INITIAL

D.O.B.: _____ Occupation: _____ Sex: M F

Personal History

(Symptoms or Disorders relating to the following:)

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Trouble, Palpitations	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lungs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bronchitis, Pneumonia, T.B.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma, Hayfever, Sinusitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach, Bowel	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hernia, Hemorrhoids, Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver Problem, Jaundice, Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney, Bladder, Urinary	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prostate, Testes (Males)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skin Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid, Endocrine, Lymphatic	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy, Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Migraines, Headaches, Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emotional/Mental Illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia, Blood Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Disorders/Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV/Aids	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye, Ear, Nose, Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug/Alcohol Addiction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other: _____		

Prevention

Do you have a "living will"?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of packs per day? _____		
<input type="checkbox"/> Interested in stopping?		
Do you drink alcoholic beverages?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been exposed to any activity which puts you at risk for AIDS?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use any substance such as cocaine, Marijuana, or other street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please list: _____		

The Last Time You

<i>Had A:</i>	<i>(Year)</i>
FLU Vaccine	_____
Tetanus Shot	_____
Hepatitis B Vaccine	_____
Pneumonia Vaccine	_____
Lyme Vaccine	_____
Rectal Exam	_____
T.B. Skin Test	_____
Stool Blood Test	_____
Sigmoid Exam	_____
Mammogram	_____
PAP Test	_____
Prostate Exam/PSA	_____
Cholesterol Test	_____
EKG	_____

Do you want to have any of the above tests or vaccines?
 Yes No

Family History

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emotional Illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other: _____		

Patient Signature: _____