Suburban Healthcare Associates

Adult Health History Questionnaire

New Patients: Please fill out to the best of your ability.

Established Patients: Please help us update our records since your last annual exam.

Current Health Concerns:

_____

_____

Health System Review
Check if you have any symptoms or problems.

General
- ☐ unexplained weight loss or gain ___ pounds
- ☐ fevers/night sweats
- ☐ fatigue
- ☐ daytime sleepiness
- ☐ swollen or enlarged lymph glands

Eyes/Ears/Nose/Throat
- ☐ recent change in vision
- ☐ date of last eye exam ___/___/___
- ☐ hearing loss
- ☐ vertigo or dizziness

Abdomen
- ☐ swallowing difficulty
- ☐ heartburn/indigestion
- ☐ abdominal pain
- ☐ vomiting blood
- ☐ black or bloody bowel movements
- ☐ change in bowel habits

Emotional Health
- ☐ anxiety, nervousness
- ☐ persistent sadness, crying spells
- ☐ feeling hopeless
- ☐ thoughts of death
- ☐ irritability
- ☐ sleep problem
- ☐ excessive worrying
- ☐ trouble getting along with people
- ☐ victim of abuse (physical, financial, sexual)

Skin/Glands
- ☐ change in mole or skin lesion of concern
- ☐ increased thirst or urination

Heart/Lungs
- ☐ chest pain with activity
- ☐ palpitations
- ☐ fainting
- ☐ leg pain with exertion
- ☐ leg swelling
- ☐ persistent cough
- ☐ shortness of breath/wheezing

Urinary/Genital/Breast
- ☐ urine leakage
- ☐ difficulty urinating
- ☐ sexual difficulty
- ☐ sexually transmitted disease exposure
- ☐ menstrual concern
- ☐ vaginal discharge, odor, itching
- ☐ penile discharge
- ☐ breast lump or nipple discharge
- ☐ testicular lump or swelling

Muscles/Neurologic
- ☐ numbness or tingling
- ☐ balance or walking problems
- ☐ falls
- ☐ headaches
- ☐ memory difficulties
- ☐ muscle pain/muscle weakness

Please turn over to complete other side

List all prescription medications, over the counter medications, vitamins/supplements you are currently taking, include dosage:

_____ _____
_____ _____
_____ _____
_____ _____

Reactions or allergies to medications: _____
_____

Specific medical events and chronic problems (Hospitalizations, asthma, hypertension, etc.):

_____ _____
_____ _____
_____ _____
_____ _____

Operations (gall bladder, appendix, etc.): **_____**
_____

Vaccinations:	**Year given**		**Year given**
☐ Tetanus	_____	☐ Meningococcal	_____
☐ Pneumonia	_____	☐ Shingles	_____
☐ Hepatitis A	_____	☐ HPV (cervical cancer)	_____
☐ Hepatitis B	_____		

Habits:
Alcohol: __none drinks/day___drinks/week___Type: __wine __beer __hard liquor
Cigarettes/tobacco: __yes/no # of packs/day _____ Quit date: _____
Caffeine: __none __coffee __tea __other #of 8 oz. cups/day: _____
Other drugs (marijuana, cocaine…): _____

Nutrition: Is there anything I should know about your eating habits? _____

Exercise: Type _____ Minutes/day _____ days/week _____

Occupation: _____ **Safety:** Y / N seatbelts Y / N smoke detectors

Relationship Status: __ Single __Married __Divorced __Separated __Widowed
__Lesbian/Gay __Bisexual __Long-term relationship __Partner/Spouse

Family History: of cancer, diabetes, early heart disease, blood problems, other hereditary problems._____
_____

Thank you for taking the time to fill out this form. It will be reviewed by the physician and will become part of your record.
Patient Signature _____ Date _____

Doctor's Signature _____ Date _____