Suburban Healthcare Associates

Adult Health History Questionnaire

Your name			**Today's Date**
Birthdate ___/___/___	☐ Male ☐ Female	__Single __Domestic Partner __Married __Divorced __Widowed	**Next of Kin**
Primary Phone	**Work Phone**		**Occupation**

What specific HEALTH PROBLEMS do you want to talk about when you are seen in the clinic?

ALLERGIES **NONE ☐**

List any medications or other substances that you are allergic to or have had a reaction to:

PRESCRIPTION MEDICATIONS **NONE ☐**

List any prescription medications you are currently taking (bring bottles or a list with you if possible):

Medication	Dosage	Frequency	Medication	Dosage	Frequency

NON-PRESCRIPTION MEDICATIONS **NONE ☐**

List any non-prescription medications (laxatives, vitamins, aspirin, antacids, cold remedies, etc.):

HOSPITALIZATIONS/SURGERIES **NONE ☐**

List type of illness/operation/place/year:

VACCINATIONS (Include year if known) **Last tuberculosis skin test date:**

Measles	Mumps	Rubella	Tetanus	Polio	Hepatitis	Pneumonia
☐_____	☐_____	☐_____	☐_____	☐_____	☐_____	☐_____

Check if you have had any of the following?

- ☐ Anemia
- ☐ Asthma
- ☐ Cancer: Type_____ Date_____
- ☐ Emphysema
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Kidney stones
- ☐ Liver disease, jaundice, hepatitis
- ☐ Migraine
- ☐ Serious injury or accident
- ☐ Sugar Diabetes
- ☐ Thyroid gland trouble
- ☐ Tuberculosis or positive skin test to TB
- ☐ Sexually transmitted disease
- ☐ Transfusions

WOMEN'S HEALTH HISTORY

_____ Number of pregnancies

_____Age of first menstrual period

_____Age of menopause

Current types of contraception:

_____

- ☐ Have you been on the pill? When? _____
- ☐ Have you been on estrogen replacement?
- ☐ Taking calcium?
- ☐ Dieting or taking diet pills?

PLEASE CONTINUE TO THE OTHER SIDE

Tobacco ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Chew Years: _____ Daily Amount: _____ **Caffeine** Cups per day: _____ Type: _____ **Alcohol** ☐ Beer ☐ Wine ☐ Liquor Average units/week:___	____Hours of sleep per night ____ Meals per day ☐ Do you use other drugs? ☐ Do you exercise? ☐ Do you use seatbelts? ☐ Do you use bicycle helmets? ☐ Do you use smoke detectors?

Please mark any of the following symptoms that are currently affecting you:	
CONSTITUTIONAL ☐ Unexplained fever ☐ Fatigue ☐ Night sweats ☐ Other:_____	**METABOLIC/ENDOCRINE** ☐ Excessive thirst ☐ Excessive hunger ☐ Cold or heat intolerance ☐ Other:_____
HEAD, EYES, EARS, NOSE, THROAT ☐ Severe headaches ☐ Ear or hearing trouble ☐ Vision changes ☐ Other: _____	**NERVOUS SYSTEM** ☐ Dizziness ☐ Excessive nervousness ☐ Other:_____
RESPIRATORY/LUNGS ☐ Daily cough ☐ Wheezing ☐ Shortness of breath ☐ Other:_____	**DERMATOLOGY/SKIN** ☐ Rashes ☐ Itches ☐ Other:_____
HEART ☐ Chest pain ☐ Heart palpitations (skipped beats) ☐ Other:_____	**BONES/JOINTS/MUSCLES** ☐ Joint pain or swelling ☐ Muscles weakness ☐ Other:_____
VASCULAR ☐ Leg vein trouble ☐ Clotting problems ☐ Other:_____	**BLOOD** ☐ Excessive bleeding ☐ Excessive bruising ☐ Other:_____
STOMACH/INTESTINAL ☐ Frequent nausea or vomiting ☐ Constipation ☐ Diarrhea ☐ Other:_____	**IMMUNOLOGY** ☐ Food allergies ☐ Environmental allergies ☐ Other:_____
URINARY ☐ Blood in urine ☐ Unusual discharge ☐ Other:_____	**Which of your blood relatives have had any of the following?** _____Early coronary heart disease _____Diabetes _____High blood pressure _____Mental or emotional disease _____Tuberculosis _____Alcohol or substance abuse
GYNECOLOGY ☐ Changes in menstrual flow ☐ Excessive cramping ☐ Vaginal discharge ☐ Other:_____	
	CHILDREN Number of children:_____ Health status:_____

FOR PROVIDER ONLY

Questions above and positive responses were reviewed by me.

Provider Signature:_____ Date:_____