Northern Nevada MEDICAL GROUP

# ADULT HEALTH QUESTIONNAIRE

Patient Name: _____

Patient Date of Birth: _____ Today's Date: _____

What would you like to talk to your doctor about today?

_____

## MEDICATIONS

Patient Pharmacy: _____

**Please list <u>all</u> medications, including over the counter medications, prescriptions medications, and vitamin supplements** (Or attach complete medication list):

*Medication Name and Strength/Frequency*

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

## ALLERGIES

**Please list all medication, environmental, and food allergies:**

*Allergy and Reaction*

_____ _____
_____ _____
_____ _____

## MEDICAL HISTORY

**Please check to indicate if you have ever had the following conditions:**

_ Arrhythmia
_ Asthma
_ Cancer Type _____
_ Congestive Heart Failure
_ Coronary Artery Disease
_ Depression
_ Diabetes
_ Emphysema/COPD
_ Heart attack
_ Hepatitis
_ High blood pressure
_ Kidney disease
_ Seizures
_ Stroke
_ STD Type: _____
_ Thyroid disease
_ Tuberculosis

_ Other, please explain: _____

**Please list any surgeries or hospital stays you have had and their approximate date/year:**

| *Type of surgery / reason for hospitalization* | *Date* |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Are you currently receiving care from any other doctors, chiropractors, or other health care professionals? If yes, we would like to know who so that we can we can coordinate your care.**

| *Provider's Name* | *Condition they are treating you for* |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Please note dates of your most recent immunizations** (or attach immunization record):

| | *Approximate Date* | | *Approximate Date* |
|---|---|---|---|
| Tetanus | _____ | Influenza | _____ |
| Prevnar 13 | _____ | Zostavax (Shingles) | _____ |
| Pneumovax | _____ | | |

**If you have had any of the following testing, please note when it was performed and what the results were, if known:**

| *Test* | *Approximate Date* | *Result* |
|---|---|---|
| Bone Density (Dexa) | _____ | _____ |
| Cholesterol | _____ | _____ |
| Colonoscopy | _____ | _____ |
| Diabetic Foot Exam | _____ | _____ |
| Eye Exam | _____ | _____ |
| Mammogram | _____ | _____ |
| Pap smear/pelvic | _____ | _____ |

**Check any of the diseases that run in your family and please note who had it:**

| | None | Mother | Father | Sister | Brother | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather | Other: Please Explain |
|---|---|---|---|---|---|---|---|---|---|---|
| Alcoholism or Drug Use | | | | | | | | | | |
| Arthritis | | | | | | | | | | |
| Asthma | | | | | | | | | | |
| Cancer (Indicate Type) | | | | | | | | | | |
| Diabetes | | | | | | | | | | |
| Heart Disease | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | |
| High Cholesterol | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | |
| Mental Illness | | | | | | | | | | |
| Osteoporosis | | | | | | | | | | |
| Stroke | | | | | | | | | | |
| Thyroid Disease | | | | | | | | | | |
| Other: Please Explain | | | | | | | | | | |

## Social History

Do you smoke or use any tobacco products? …… ☐Yes ☐No ☐Former Smoker
Number of cigarettes each day? _____ Quit Date:
For how many years? _____
Other forms of tobacco used? _____
Do you drink alcohol?..... ☐Yes ☐No ☐Recovery
How much? _____ Recovery Date:
How Often? _____
What type? _____
Do you use recreational drugs? …… ☐Yes ☐No ☐Recovery
How much? _____ Recovery Date:
How Often? _____
What type? _____
Are you currently married or living with a significant other? …… ☐Yes ☐No
Who lives with you at home? _____
Are you currently employed? …… ☐Yes ☐No
If yes, type of employment: _____
If no, are you disabled? _____ Other reasons? _____

## Sexual History

Are you sexually active? …… ☐Yes ☐No

With: ☐ Men ☐ Women ☐ Both

Do you have children? …… ☐ Yes ☐ No

How many children do you have? _____

Do you use any form of protection? …… ☐ Yes ☐ No

If yes, which type? _____

## Women Only

Do you currently see a gynecologist? …… ☐ Yes ☐ No

If yes, name of provider: _____

Have you ever been pregnant? …… …… ☐ Yes ☐ No

How many times? _____

How many miscarriages? _____

How many abortions? _____

How many children do you have living? _____

Do you have menstrual periods? …… ☐ Yes ☐ No

If no, at what age did they stop? _____

If yes, are your periods regular? _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____