Community Medical Associates

~Adult Health Questionnaire ~

Name: ______________________________

Date: _________ Date of Birth: ____________

Preferred Pharmacy: ____________________ Street: _________________________

Past Medical History: (Please indicate YEAR of Surgery)

__None	__Breast Surgery	__ Ear tube	__Hysterectomy
__Ablation	__Cataract	__EGD	__Prostatectomy
__ Appendectomy	__Colonoscopy	__Gallbladder Surgery	__Sinus Surgery
__Back Surgery	__ C-Section	__ Heart Bypass	__Spine Surgery
__Bowel/Colon Surgery	__Device/Implant Surgery	__Hernia Repair	__Tonsillectomy
__Other (Explain below)			

____

Current Medications with Strength and Dose ___ See attached list

____

____

Immunization Dates

(Please write the YEAR of the Immunization, if unknown write UNKNOWN)

Flu Vaccine_____________

Pneumonia _____________

Tetanus_______________

Hepatitis A _____________

Hepatitis B _____________

Measles/ Mumps __________

Chicken Pox _____________

Other ________________

Drug Allergies

(List Reaction to the Right)

__None __Penicillin____

__Codeine________

__Sulfa ___________

Other_______________

Social History:

Smoking Status:

__Never Smoked

__Former Smoker

__Current every day smoker

__ Current some day smoker

How many packs per day?____

Smoked since age of ___

Passive smoke exposure: __Yes __No

Do you chew tobacco: __Yes __No

How many cans per day? ____

Alcohol intake:

__None

__Occasional

__Moderate

__Heavy

Illicit drug use: __Yes __No

If yes, what ___________________

Occupation:

____

__ Retired

__Disabled

__ Unemployed

Marital Status:

__Single

__Married

__Divorced

__Separated

__ Widowed

__ Domestic Partner

Exercise Level:

__None

__Occasional

__Moderate

__Heavy

Caffeine Consumption?

How much? ___________

Adult Health Questionnaire Community Medical Associates

Past Medical History: (check all symptoms/diseases that apply to your Past Health)

__ADD
__ADHD
__Alzheimer's
__Anemia/Blood Disorder
__Aneurysm
__Anxiety disorder
__Arthritis
__Asthma
__Atrial Fibrillation
__Back/Neck Problems
__Bipolar
__Bladder or kidney problems
__Blood Clots
__Bowel problems
__Broken bones
__Claustrophobic

__Cancer: Type__________
____
__ Colon polyps
__ Congestive Heart Failure
__ COPD
__Coronary Artery Disease
__Dementia
__Depression
__Diabetes
__Diverticulitis
__Dizziness
__Ear Problems
__Edema
__Endometriosis
__Epilepsy
__Eye Problems
_Fibrocystic Disease
__GERD

__GOUT
__Headaches
__Hearing Loss
__Heart Disease
__Heart Murmur
__ Heartburn/Reflux
__Hepatitis/ Liver disease
__High blood pressure
__High Cholesterol
__HIV/AIDS
__Hormone issues
__Indigestion
__Irregular periods
__Kidney disease
__Lightheadedness
__Lupus
__Metal Implants
__Heart Attacks

__Migraines
__Osteoporosis
__Ovarian Cyst
__Palpitations
__Pneumonia
__Psychological disorder
__Renal Failure
__Seizures
__Sleep disorder
__Stress incontinence
__Stroke
__Thyroid disease
__Ulcer
__Urinary/Bladder problems
__Vaginal Discharge
__Vaginal Dryness
__Other ____________
____

Family History (Include relationship and also maternal or paternal)

__Adopted

Alcoholism________________
Allergies________________
Alzheimer's disease ________
Anemia________________
Aneurysm________________
Anxiety________________
Arthritis________________
Asthma________________
Blindness________________
Blood coagulation disorder_____
____
Cancer & Type: __________
____
Cataracts________________
Coronary Artery Disease______
COPD________________
Crohn's disease__________
Dementia________________
Depression________________
Diabetes________________
Digestive disease__________
Drug dependence__________
Epilepsy________________
Glaucoma________________
Headaches________________
Hearing loss______________
Heart Disease_____________
Hepatitis________________
High blood pressure________
High cholesterol___________
Immune problems__________
Jaundice________________
Kidney disease____________
Liver disease_____________
Mental disorder___________
Mental retardation_________
Multiple sclerosis_________
Osteoporosis_____________
Palpitations_____________
Pancreatitis_____________
Parkinson disease_________
Peptic ulcer disease_______
Polyps________________
Seizure________________
Stroke________________
Thyroid disease___________
Tremors________________
Tuberculosis______________

Childhood Illness (Mark any past illnesses)

__Measles __Mumps
__Rubella __Chickenpox
__Rheumatic Fever __Polio

Hospitalizations within the past year

Reason	Hospital

Adult Health Questionnaire Community Medical Associates

Please name any specialist you have seen within the past 5 years.	**Prevention: (give YEAR if you have had any of the following done)**
OB/GYN___	Chest X-ray___
Allergist___	EKG___
Cardiologist___	Hearing Test___
Ophthalmologist___	Eye Vision Test___
Surgeon___	Bone Density Test___
Dermatologist___	Colon Cancer Screening___
Urologist___	Lab/Blood Tests___
Gastroenterologist___	
Orthopedic___	
Neurologist___	
Other___	

Special Learning or Communication needs? ___Spanish Speaking only __Hearing Impaired __Visually Impaired

___

___

___

Men only

How many times do you urinate during the night? ____

Do you feel pain/burning with urination? ____

Any blood in your urine? ___

Has the force of your urination decreased? ___

Have you had any kidney, bladder or prostate infections within the past 12 months? ___

Do you have problems emptying your bladder completely? ___

Any difficulty with erection or ejaculation? ___

Any testicle swelling? ___

Date of last prostate exam? __/__/__

Date of last rectal exam? __/__/__

What method of birth control do you use? ___________

___

Women only

Date of last mammo __/__/___

Abnormal mammo? ____ If yes, when? ______

Date of last menstrual period __/__/____

Age at onset of menstrual period __/__/____

Date of last pap __/__/____

Abnormal pap smear? If yes, when? _____

Current method of birth control

__IUD __Depp Provera __Nuvaring

__Implanon __Diaphragm __Condoms

__Birth Control Pills __Tubal Ligation

__Spermicide __Partner Vasectomy

__Hysterectomy _None __Multiple

Number of live births ____

Number of pregnancies ____

Type of delivery?

__Vaginal __C-section __Both

Have you ever had an induced abortion? __Yes __No

If yes, when? ___