Premier Community HealthCare Group, Inc.

Adult Medical History Questionnaire

What is the main reason you came to the doctor today? ____
____

Please check (✓) next to any illnesses or problems that apply to you. Include dates if possible.

General
( ) cancer
( ) diabetes
( ) thyroid problems
( ) recent change in weight
( ) weakness, fatigue
( ) fevers, night sweats
( ) swollen areas (lumps, knots)
( ) serious injuries

Skin
( ) skin cancer
( ) sores, skin infection
( ) rashes, hives

Nervous System
( ) stroke
( ) seizures, epilepsy
( ) frequent dizzy
( ) trouble sleeping
( ) frequent headache
( ) depression, anxiety
( ) mental illness
( ) alcohol, drug abuse

Eyes
( ) glaucoma
( ) trouble with vision

Ears
( ) ear infections
( ) trouble hearing

Nose, Mouth
( ) hay fever, sinus problem
( ) sores in mouth
( ) wear dentures

Heart and Blood Vessels
( ) heart attack
( ) high blood pressure
( ) frequent chest pain
( ) palpitations
( ) ankle swelling

Lungs
( ) asthma
( ) emphysema
( ) tuberculosis
( ) shortness of breath
( ) nagging cough
( ) hoarseness

Gastro-intestinal
( ) stomach ulcer
( ) gall bladder
( ) indigestion, heartburn
( ) hepatitis, yellow jaundice

Rectum
( ) hemorrhoids
( ) frequent diarrhea
( ) black or bloody stools

Kidney
( ) kidney stones
( ) bladder, kidney infection
( ) problems with urination- hesitancy, loss of control

Bones and Joints
( ) arthritis, rheumatism
( ) gout
( ) back or neck problems
( ) foot problems
( ) use of cane, crutches, walker or wheelchair

Blood
( ) sickle cell
( ) bleeding problems
( ) anemia
( ) blood transfusion

Males Only
( ) enlarged prostate
( ) painful or lumpy testicles
( ) problems with sex

Females Only
( ) lumps in breast
( ) frequent yeast infections
( ) unexpected vaginal bleeding
How many children have you had?_______
How many times pregnant? ___________
Have you ever had a C-section?________
When was your last period? __________
Are your periods regular? ____________
How many days do they last?_________
Date last Pap? ______ Results _______

Do you have any other medical problems?
____
____
____
____

HOSPITAL AND SURGERY – Please list all hospital admissions, and any other surgeries.

Year	Hospital, city, and state	Reason for admission, or type surgery
________	______________________________	______________________________
________	______________________________	______________________________
________	______________________________	______________________________

X-RAYS, OTHER TESTS – Please list the last year that any of the following were done.

X-Rays	Year	Results	Other Tests	Year	Results
Chest	_______	____________________	Mammogram	_______	____________________
Stomach (Upper GI)	_______	____________________	Cholesterol measurement	_______	____________________
Gall Bladder (Ultra-sound)	_______	____________________	Cardiac Stress Test (Treadmill)	_______	____________________
Colon (Barium enema)	_______	____________________	Eye Examination	_______	____________________
Kidney (IVP)	_______	____________________	Dental Examination	_______	____________________
Back/Neck	_______	____________________	Other ________________	_______	____________________

MEDICATIONS – Please list all medicines that you use frequently or every day. Include prescription medicines, aspirin, antacids, vitamins, birth control pills, etc.

Medication	Dose	How Often	Medication	Dose	How Often
1			5		
2			6		
3			7		
4			8		

Allergies ________________________________ **Acct. #:** ________________ Today's Date ________________________

NAME: __________________ **DOB:** _____________ Reviewed by: ____________________________

Please complete both sides

Family History – Please fill in blanks and check (✓) appropriate items in top row.

Family Member	Age	If deceased, give age and cause of death	Allergies	Cancer	High Blood Pressure	Heart Problems	Stroke	Diabetes	Kidney Problems	Osteoporosis	Sickle Cell	Tuberculosis	AIDS	Seizures, Epilepsy	Mental Illness	Depression, Anxiety	Alcoholism	Other
Father																		
Mother																		
Other "blood" Relatives- Brothers, Sisters, Grandparents																		

Social History – Please circle responses, or fill in blanks.

1. What is your usual occupation? __________ What kind of work do you do now? __________ Seasonal/Migrant? __________
2. What is the highest grade in school you completed? ________ 3. Are you? Single Married Divorced Separated Widowed
4. Do you exercise? Never Rarely Once a week 3-4 times/week Type of exercise ________________________________
5. Do you use tobacco? _____ Cigarettes Cigars Pipe Snuff Chewing tobacco How may packs/day? ________________
6. How many years have you smoked? ________________ If you have quit smoking, when? ______________________
7. Do you use alcohol? _______________ In a week, how many cans of beer_____, glasses of wine_____, shots of liquor_____?
8. How many cups of coffee, tea, or cola, do you drink in a day? ____
9. DO you sometimes use marijuana or other drugs, socially? ____
10. Have you had more than one sexual partner in the last year? ____
11. Have you ever had a sexually-transmitted disease, such a gonorrhea, syphilis, or herpes? ______________________
12. Have there been any unusual stresses in your life in the last year?
    Broken relationships? Illness or death in the family? Change in job? Moved? Other____________

Household members – Who lives in your house?

Name	Age	Relationship	Any medical/drug/school/work problems?

NAME: ______________________________ **DOB:**______________________ **Acct. #:** ____________

Please complete both sides