PATIENT HEALTH HISTORY QUESTIONNAIRE

ADVANCED ADULT CLINIC

Patient Information:

Name: _____

Date of Birth: _____ Marital Status: ❑ Single ❑ Married ❑ Divorced/ Separated ❑ Partnered

Medical Information:

Do you have any major health concerns or questions that you would like to discuss with the health care provider?

_____

_____

_____

Past Medical History: *(Check all items that apply to you and fill in the blanks as needed)*

__allergies
__anemia or blood problems
__arthritis
__asthma
__blood transfusion, year_____
__cancer/tumor, type_____
__chickenpox, year_____
__COPD/emphysema
__diabetes
__drug or alcohol abuse
__epilepsy or seizure
__hearing loss
__heart disease or heart attack
__hepatitis
__HIV/AIDS
__high blood pressure
__kidney disease or stones
__ulcer disease or reflux
__depression/anxiety
__other mental illness
__sexually-transmitted disease
__skin disease, eczema, psoriasis
__stroke
__thyroid disease
__other, specify_____
_____
_____

Past Surgical History: _____

_____

_____

Medications: (*List all medications with dosages, include over-the-counter medications and herbs*)

_____

_____

_____

_____

Allergies:

❑ No known drug allergies

Allergic to Drug:_____ Reaction: _____

Drug:_____ Reaction: _____

❑ No known food or environmental allergies (peanuts, bees, pollen, etc)

Allergic to Food/Other: _____ Reaction: _____

Food/Other: _____ Reaction: _____

Preventive Services: (*Please list the date that you last had these tests or procedures.)*

Physical: ❑ Never or Date: _____
Lipid/cholesterol panel: ❑ Never or Date: _____
Colonoscopy: ❑ Never or Date: _____
Bone density or DEXA scan: ❑ Never or Date: _____
Immunizations

Tetanus	Date _____	Influenza (Flu)	Date _____
Hepatitis B	Date _____	Pneumonia	Date _____
Chicken Pox	Date _____	Gardasil (HPV)	Date _____
Zoster (shingles)	Date _____		

If you do not know your immunization history, please indicate the doctor or office that may have immunization records:

Name: _____
Address: _____
Phone Number: _____

Women Only: Date of last Pap smear:_____ Date of last mammogram:_____

Risk Assessment/Social History:

Do you currently smoke? ❑ No ❑ Yes If yes, how many packs per day ____ for how many years _____
Did you smoke in the past? ❑ No ❑ Yes If yes, when did you quit? _____
Have you had exposure to smoke now or in the past? ❑ No ❑ Yes How long: _____
How many alcoholic drinks do you have in a typical day? _____
Have you used illegal or recreational drugs in the past year? ❑ No ❑ Yes
Has anyone complained about your drug or ETOH use? ❑ No ❑ Yes
How many caffeinated beverages do you have per day? _____
Are you on a special diet (vegetarian, gluten free, etc)? ❑ No ❑ Yes If yes, specify: _____

How many hours of sleep do you get on a typical night? _____
Do you exercise regularly? ❑ No ❑ Yes (specify how often) _____
Do you wear helmets for sports (biking, skiing, etc)? __No __Yes __ N/A
Do you use a seatbelt? ❑ No ❑ Yes
Do you use contraception if you are sexually active? ❑ No ❑ Yes ❑ N/A
Do you practice safe sex if you are sexually active? ❑ No ❑ Yes ❑ N/A
Have you ever been a victim of abuse? ❑ No ❑ Yes When: _____

Have you been exposed to hazardous material? ❑ No ❑ Yes If yes, specify: _____
Do you have smoke detectors in your home? ❑ No ❑ Yes

Do you have carbon monoxide detectors in your home? ❑ No ❑ Yes

Have you often been bothered by feeling down, depressed, or hopeless? ❑ No ❑ Yes

Have you often been bothered by little interest or pleasure in doing things? ❑ No ❑ Yes

Do you have a health care proxy or advanced directive? ❑ No ❑ Yes

With whom do you live? _____

Are you …. ? ___ employed; type of employment _____
___ homemaker
___ retired
___ full-time student: field of study _____
___ disabled: reason / year _____
___ other; specify _____

Family History:

	Mother	Father	Grandparent	Brother/Sister	Child
Alzheimers					
Asthma					
Arthritis					
Allergies					
Alcoholism					
Blood disorders					
Cancer (specify type)					
Depression/anxiety					
Other mental illness					
Diabetes					
Heart disease					
High blood pressure					
Stomach/intestinal disease					
Stroke					
Skin disease					
Thyroid problem					
Current Age(s)or Age at death					

Other Health Care Providers:

Do you have a…?		**Name and address**
Dentist	❑ No ❑ Yes	_____
Eye doctor	❑ No ❑ Yes	_____
Mental health	❑ No ❑ Yes	_____
OB-GYN	❑ No ❑ Yes	_____
Other		_____

Review of Systems:

(check any of the following that you have or have had in the past 6 months)

Skin		**Neurologic**	
	Rashes		Seizures
	Change in a wart or mole		Paralysis
Ear nose and throat			Numbness or tingling
	Nosebleeds		Dizziness
	Allergies		Balance problems
	Sinus problems	**Digestion**	
	Eye pain		Heartburn or reflux
	Trouble seeing		Ulcer
	Glaucoma		Nausea/vomiting
	Double vision		Diarrhea
	Ear pain		Constipation
	Trouble hearing		Abdominal pain
	Hoarseness		Black or bloody stool
	Frequent sore throats		Liver or gallbladder trouble
Respiratory			Jaundice or yellow skin
	Shortness of breath	**Urinary**	
	Wheezing		Pain on urination
	Cough		Frequent urination
	Coughing blood		Frequent urination at night
Cardiovascular			Inability to hold urine
	Heart attack		Blood and urine
	Chest pain		Kidney stones
	Murmur	**Mental/emotional**	
	Irregular heartbeat/ palpitations		Anxiety
	Swelling in ankles		Depression
Endocrine			Poor concentration
	Heat intolerance		Poor memory
	Cold intolerance	**General**	
	Excessive thirst		Poor sleep/insomnia
	Excessive urination		Fatigue/low energy
	Hair loss		Fever/chills
	Change in weight		Poor appetite
Muscles/joints/bones		**Women only**	
	Joint pain		Change in periods
	Muscle pain		Vaginal itching or discharge
	Osteoporosis		Breast lumps
	Joint swelling		Bleeding after menopause
		Men only	
			Testicular swelling
			Change in urinary stream