ADULT HEALTH HISTORY QUESTIONNAIRE

CONFIDENTIAL

PAST ILLNESSES

Please check any illnesses you have had.

_____ Asthma
_____ Hay fever
_____ Emphysema
_____ TB
_____ Kidney Trouble
_____ High blood pressure
_____ Rheumatic fever
_____ Diabetes
_____ Stroke
_____ Cancer _____
_____ Anemia (type)
_____ Arthritis
_____ Gout
_____ Abnormal Pap smear
_____ Stomach Ulcer
_____ Mental illness
_____ Seizures
_____ Depression
_____ Back trouble
_____ Bowel trouble
_____ Thyroid disease
_____ Glaucoma
_____ Gallstones
_____ Hepatitis
_____ Liver problems
_____ Bleeding problems
_____ Skin problems
_____ Alcohol problem
_____ Drug addiction
_____ Hearing loss
_____ Polyps of bowel
_____ Sexually transmitted disease
_____ HIV
_____ Other:_____

MEDICATIONS/ALLERGIES

List current medications you take and/or allergies you have:

Medications:

_____
_____
_____
_____
_____
_____

Allergies:

_____

WOMEN ONLY

Age at 1st menstrual period____
# of times pregnant ____
# of living children ____
Date of last Pap smear ____
Age when periods stopped ____
Birth control method:

_____

MEN & WOMEN

Do you consider yourself to be:
___heterosexual (straight)
___homosexual (lesbian/gay)
___bisexual

HOSPITALIZATIONS/SURGERIES INJURIES

Please list any hospitalizations, surgeries, &/or injuries you have had:

_____
_____
_____

FAMILY HISTORY

Please circle any diseases your parents, grandparents, brothers, sisters, aunts, or uncles have had:

Diabetes Asthma Stroke Cancer (type)_____
Alcoholism Seizures Heart Attack High Blood Pressure
Other:_____

NAME: _____ **DATE OF BIRTH:** _____

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PERSONAL HISTORY

	Check Yes	No
Do you have any trouble reading?	_____	_____
# years of school completed _____		
Do you have any special interests or hobbies?	_____	_____
Please list _____		
Do you have any personal concerns which are troubling you?	_____	_____

If "yes", please check those concerns:

____ Hospital bills	____Family	____Housing/Rent/Heat
____ Social Security	____Marriage	____Other Money Matters (food, clothing, etc.)
____ Occupation	____Sex	____Community Agencies (Welfare, etc.)
____ Transportation	____Loneliness	____Emotional Problems/Nerves
____ Legal	____Death	____Other _____

	Yes	No
Would you like to talk with a counselor or social worker?	_____	_____
Would you like to talk with a nutritionist ?	_____	_____
Do you get regular dental check-ups?	_____	_____
Do you exercise at least 3 times a week?	_____	_____
Are you satisfied with your sex life?	_____	_____
Do you always wear your seat belt?	_____	_____
Do you keep a gun in your home?	_____	_____
Do you have smoke detectors in your home?	_____	_____
Do you limit sun exposure or use sunscreens (#15 or higher) when tanning?	_____	_____
Have you ever been physically or sexually abused?	_____	_____
Do you smoke cigarettes?	_____	_____
Packs per day _____ Years _____		
Do you smoke cigars?	_____	_____
Do you use snuff or chewing tobacco?	_____	_____
Do you drink alcohol (beer, wine or mixed drinks)?	_____	_____
# drinks per day _____		
Have you ever felt a need to cut down on your drinking?	_____	_____
Have you ever been annoyed by criticism of your drinking?	_____	_____
Have you ever had guilty feelings about your drinking?	_____	_____
Do you ever drink a morning eye-opener?	_____	_____
Do you smoke pot?	_____	_____
Do you use other drugs?	_____	_____

The rest of these questions are for you to see if you might be at risk to get AIDS. You do not have to write down your answers, but if any answers are "yes", you could be at risk for AIDS and you should talk to your practitioner about it.

	Yes	No
Have you had more than one sexual partner in the past year?	_____	_____
Has your partner had sex with anyone other than you, since you have been partners?	_____	_____
Have you or your sexual partners ever used IV drugs?	_____	_____
Have any of your sexual partners had AIDS or a positive HIV test?	_____	_____
Have you ever had a venereal disease (VD)?	_____	_____

Patient Registration Form

FAMILY MEMBER (Spouse, Children, Parents, Brothers, Sisters who reside in your home)

Relationship	First Name	MI	Last Name	Social Security #	Birth Date

PRIMARY INSURANCE INFORMATION

Carrier (Circle) 1. Private Insurance 2. Medicare (Complete MSP) 3. Medical Assistance
4. Other Private Insurance: Name _____
5. Farmworker _____
6. None/Uninsured _____

Name On Policy	Sex	Group #	Policy#	Relationship to Patient	Dental Coverage

SECONDARY INSURANCE INFORMATION

List other insurance which would pay after your primary insurance has paid:

Carrier (Circle) 1. Private Insurance 2. Medicare (Complete MSP) 3. Medical Assistance
4. Other Private Insurance: Name _____
5. Farmworker _____
6. None/Uninsured _____

Name On Policy	Sex	Group #	Policy#	Relationship to Patient	Dental Coverage