Health History Questionnaire

PROVIDENCE Health & Services

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ADULT HISTORY (age 18+)

NAME:	DATE OF BIRTH:	AGE:	Today's DATE:

What concerns do you have about your health that you want to discuss today?

Past Medical History: **Date of Onset:** **Resolved**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Have you had any **Surgeries**? _____ YES (Please list) ____ NO

_____ _____
_____ _____
_____ _____

Are you currently taking any **Medications**? _____ YES (Please list) ____ NO

Medication	Dose	How many times per day?	When Started?

Do you have any **Known Drug Allergies**? _____ YES (Please list) ____ NO

_____ _____
_____ _____

GENERAL HEALTH QUESTIONS: (Please circle any you've had over the last 3 months)

Skin Rashes	Dizziness	Frequent or severe headaches	Seizures
Eye problems	Ear problems	Difficulty swallowing	Sinus problems
Frequent coughing	Trouble breathing	Wheezing	Lots of fevers
Chest Pains	High Blood Pressure	Swollen Legs	Sexual Problems
Nausea Vomiting	Stomach Pains	Diarrhea Constipation	Blood in Stool
Problems Urinating	Feel like you are constantly going to the bathroom to urinate (pee)		
Always feel thirsty	A change of 15 lbs or more in your weight?		
Arthritis	Pain	Trouble Walking	Trouble Sleeping
Depressed	Worried or anxious	Trouble controlling anger	

Increased bruising/bleeding compared to what you are used to?

FOR WOMEN ONLY:

When was your last Pap test? _____ When was your last Mammogram? _____

Have you EVER had a Pap test or Mammogram that wasn't normal? ___ YES ____ NO

Pregnancies: _____ # Deliveries:_____ # Abortions:_____ # Miscarriages:_____

1st day of your most recent period: _____ Age @ 1st Period_____ Regular OR Irregular

Do you have any concerns about your periods? ____YES _____ ____ NO

Do you have any concerns about menopause? ____YES _____ ____ NO

SOCIAL HISTORY:

Occupation: _____ Employer:_____

Years of Education / Highest Degree_____ Marital Status: S___ M___ D___ W___ Other___

Spouse/Partner's Name: _____ Number of Children/Ages:_____

Who lives at home with you? _____

FAMILY HISTORY:

Please indicate the current status of your immediate family members:

	Alive	Deceased	Age (now or at death)	Comments / Medical Problems
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Sister(s) #____	_____	_____	_____	_____
Brother(s) #____	_____	_____	_____	_____

HEALTH / SAFETY HISTORY:

TOBACCO Use:

Cigarettes: **Y N NEVER**

Quit? ___ / Date_____

____Current Smoker: packs/day_____ # years_____

Other Tobacco: Pipe____ Cigar____ Snuff___ Chew____

Are you interested in Quitting? **Y N**

ALCOHOL Use:

Do you drink Alcohol? **Y N** # drinks/Week _____

Are you or anyone else concerned about your alcohol Use? **Y N**

DRUG Use:

Have you ever used recreational Drugs? **Y N**

SEXUAL Activity:

Have you ever had sex? **Y N**

Current sex partner(s) is/are: ___Male ___Female

Birth Control Method: _____None needed ___

Have you ever had any sexually transmitted Diseases (STD's)? **Y N**

Are you interested in being screened for sexually transmitted diseases? **Y N**

CAFFEINE Intake:

____ None ____ Coffee/Tea: cups/day _____

Sodas/day _____ oz Chocolate/day _____

WEIGHT: Are you satisfied with your weight? **Y N**

DIET:

How do you rate your diet? __Good __Fair __Poor

Do you take Supplements? _____

Do you drink 4 large glasses of milk daily or take Calcium Supplements? **Y N**

EXERCISE / SAFETY:

Do you exercise regularly? **Y N**

What kind of exercise? _____

How long (minutes)? _____ How Often? _____

BIKE HELMET: do you use one? **Y N**

Use **SEATBELTS** consistently? **Y N**

Is **VIOLENCE** at home a concern? **Y N**

Have you been hit, kicked, punched or otherwise hurt by someone in the past year? **Y N**

Do you feel **unsafe** in your current relationship? **Y N**

Is there a partner from a **previous** relationship who is Making you feel **unsafe** now? **Y N**

Do you have a **gun** in your home? **Y N**