SCITUATE FAMILY PRACTICE
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Name: _____

Date of Birth: _____

ADULT HEALTH HISTORY QUESTIONNAIRE

Please answer as best as possible. All answers will be kept confidential.

How did you hear about this practice? _____

PAST MEDICAL HISTORY

Past/Current Medical Problems: _____

_____

_____

Operations/Hospitalizations (date, reason): _____

_____

Medications (with dose): _____

_____

Any Known Allergies to Medications: □No □Yes Which?: _____

PERSONAL HISTORY

Tobacco: Do you smoke? □Yes □Quit □Never Packs/Day: ____ Age you began smoking:____
Does anyone else smoke in the home? □Yes □No
Alcohol: Drinks/average week: _____ Other drugs you have used: _____
Regular Exercise: _____
Marital Status: _____ Level completed in school: _____
Members of Household (name, relation): _____

_____
Other children not at home: _____
Places lived outside of US: _____
Does anyone hit or hurt you: □Yes □No
Are you interested in discussing a healthcare proxy and/or advanced directives? □Yes □No

WORK HISTORY

What is your current job? _____
Is there anything now, or in past jobs or hobbies that could be hazardous (asbestos, chemicals, repetitive strain, radiation, etc.)? _____

FAMILY HISTORY

Mother: Age, if living: ____ Health problems: _____
If deceased, age at death: ____ Cause: _____

Father: Age, if living: ____ Health problems: _____
If deceased, age at death: ____ Cause: _____

Number of brothers: ____ sisters: ____ Health problems: _____

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If any apply to your family, please indicate how the person is related:

Cancer: _____ Diabetes: _____ Depression: _____

types of cancer: Heart attack: _____ Stroke: _____

Other diseases: _____

REVIEW OF SYSTEMS

In the past two weeks, how often have you:
Felt down, depressed or hopeless? □Not at all □Several days □More than ½ of days □Nearly every day
Found little interest or pleasure in doing things: □Not at all □Several days □More than ½ of days □Nearly every day

Please indicate if you have concerns in any of the following areas:
□Housing □Food □Finances □Transportation □Language barriers □Social anxiety/isolation

Which do you have, or have you had recently? Write in any other symptoms and circle any that concern you.

GENERAL
- Weight change
- Change in appetite
- Sensitivity to heat or cold
- Sexual concerns

EAR, NOSE, THROAT
- Trouble with hearing
- Trouble with vision
- Trouble with teeth or gums
- Hay fever/sinus problems
- Last eye exam: _____

HEART
- Chest pain or tightness
- Palpitations
- Swelling of legs or ankles

RESPIRATORY
- Cough/wheezing
- Hoarseness
- Shortness of breath

NEUROLOGIC
- Headache
- Sleep problems

IMMUNIZATIONS *(please provide year, if known)*
- Tetanus _____
- Hepatitis B: _____
- Pneumonia: _____
- Influenza (Flu): _____

GASTROINTESTINAL
- Stomach pain
- Nausea or vomiting
- Diarrhea or constipation
- Blood in stool/black stool
- Date of last colonoscopy: _____

URINARY
- Pain or burning
- Increased frequency
- Sexually transmitted diseases
- Frequent urinary infections

MOOD
- Anxiety
- Panic attacks
- Depression

OTHER
- Arthritis
- Back pain
- Rashes
- Changing moles

WOMEN
- Problems with periods
- Breast lumps
- Date of last mammogram: _____
- Date of last Pap smear: _____

Person completing form: _____ Date: _____