

ADULT PATIENT QUESTIONNAIRE / HISTORY		NAME	
This form provides basic health background history. It is a part of your confidential medical record		DOB	
Personal History	Occupation Marital Status PAP Smear (Date if applicable) Mamogram (Date if applicable)	Medicine Allergies Current Medications Rx / OTC	
Addiction / Dependency	Do you smoke Yes/No Do you use other tobacco product Yes/No Do you drink alcohol Yes/No Do you take illegal drugs Yes/No	If yes describe	Which Product Amount Since when Route; oral/ injection etc
Safety	Do you use seat belts yes / no		
Household Members	Names/ Relationship _____	Age / DOB _____	Health Concerns if any _____
Immunizations	Dates last given Flu	Tetanus	Hepatitis A Hepatitis B
Past Medical History	<i>Have you had any of the following/ If yes please circle it and give details</i> Diabetes / High blood pressure / Heart trouble / High cholesterol Epilepsy / Seizures / Stroke / Nervous problems / Alcoholism Allergies / Asthma / Emphysema / Arthritis / Gout Ulcers / Hepatitis / Bowel disease / Any other not listed <u>Details</u>		
Family Medical History	<i>Have any of your blood relatives had the following? If yes please circle it and give details</i> Diabetes / High blood pressure / Heart trouble / High cholesterol Epilepsy / Seizures / Stroke / Nervous problems / Alcoholism Allergies / Asthma / Emphysema / Arthritis / Gout Ulcers / Hepatitis / Bowel disease / Any other not listed <u>Details</u>		
Hospitalizations / Surgeries	Please give details with dates		
Other Concerns	Do you have any significant Health concerns / Problems that can affect your health ?		

Patient's Signature _____

Date _____