Date of Service:_____

Adult Patient Questionnaire

Please fill out the following information, this form only needs to be filled out once so we can enter the information in our new electronic health records. If you have already completed this form at a previous visit, you do not need to fill it out again.

If you are unsure of a question or do not feel well enough to complete this form, you may leave it blank and ask for assistance from the medical assistant when you are called into an exam room.

Name:_____ D.O.B:_____

Name of Physician/Provider you are seeing today:

Email: _____ Reason for visit: _____

Emergency Contact Name: _____

Relation:_____ Contact Number:_____

Chronic Illness

Do you have any current chronic illnesses? No:_____ Yes:____ If Yes, Please check all that apply:

Diabetes: _____	Crohn's Disease: _____	Heart Disease: _____	Asthma: _____
Hypertension: _____	Diverticulosis: _____	Tuberculosis:_____	Headache: _____
Seizures: _____	Poor Circulation: ____	Coronary Heart Disease: _____	Fibromyalgia: _____
Stroke: _____	Hypercholesterolemia: ____	Other:_____	

Past Medical /Surgical History

Have you had any prior serious illness or surgeries? No:_____ Yes:____ If Yes, Please list including dates if known:

_____ _____
_____ _____
_____ _____

Family History (possible genetic illnesses)

Diabetes: _____	Kidney Disease: _____	Heart Disease: _____	Asthma: _____
Hypertension: _____	Stomach Ulcers: _____	Blood Disease_____	Cancer: _____
Diverticulosis: _____	Rheumatoid Arthritis: ____	High Blood Pressure: _____	Epilepsy: _____
	Other: _____	_____	

Medications

Are you currently taking any medications? No:_____ Yes:____ If Yes, Please list medications and dosage if known:

_____ _____
_____ _____

Allergies

Are you allergic to any medications? No:_____ Yes:____
If Yes, please list medications and reactions:

_____
_____

Are you allergic to any foods? No: _____ Yes: _____
If yes, Please list foods and reactions:

_____
_____

Previous Physicians:

_____ _____
_____ _____

Patient Name: _____ Date of Service: _____

Social History

Have you ever Smoked? No: _____ Yes: _____
Do you Smoke? No: _____ Yes: _____ If Yes, please list quantity: _____
Do you drink alcohol? No: _____ Yes: _____ If Yes, please list quantity: _____
Do you drink caffeine? No: _____ Yes: _____ If Yes, please list quantity: _____
Sources of caffeine: Tea: _____ Soda: _____ Tablets: _____ Other:: _____

Exercise? No: _____ Yes: _____ How many times a week? _____
What exercises do you do? _____
_____

Do you use any illicit drugs? No: _____ Yes: _____If Yes, please list type: _____

Occupation: _____ Retired: _____
Employer: _____

Are there any occupational hazards at your place of employment, such as: asbestos, chemicals, excessive noise potentially toxic fumes? No: _____ Yes: _____ If Yes, please list: _____
_____

Health Maintenance

What is the date of your last physical? _____ None: _____
When was your last EKG? _____ None: _____

Adults age 35 or older

When was your last cholesterol lab test? _____ None: _____

Adult women only

When was your last mammogram? _____ None: _____
When was your last pap smear? _____ None: _____
When was your last DEXA scan (Osteoporosis screening)? _____ None: _____

Adults men over age 50 only

When was the date of your last prostate exam? _____ None: _____

Adults over age 50 only

When was the date of your last colonoscopy? _____ None: _____

Adults over age 50 only

When was the date of your last colonoscopy? _____ None: _____

Immunizations (approximate dates)

Date of your last flu shot? _____ None: _____
Date of your last pneumonia shot? _____ None: _____
Date of your last tetanus shot? _____ None: _____
Date of your last shingles shot? _____ None: _____
Date of your last Gardasil shots? _____ None: _____
Date of your last hepatitis B shots? _____ None: _____
Date of your last hepatitis A shots? _____ None: _____
Date of your last meningitis shots? _____ None: _____

Do you have a copy of your immunization record? No: _____ Yes: _____
If Yes, please provide a copy with this document.