ADULT HEALTH QUESTIONNAIRE

Name:_____ Date:_____

Age:_____ Occupation:_____ Marital Status: S M D

Please list your current medical condition for which you need to see a healthcare provider or are currently taking medications for on a regular basis:

ILLNESS	MEDICATIONS	DOSE/FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATION ALLERIGES:_____

OTHER ALLERGIES:_____

WOMEN ONLY: First day of last menstrual period:_____

Method of Birth Control:_____Number of Pregnancies_____

Did you have Diabetes with any of your pregnancies? YES NO

HEALTH MAINTENANCE

When did you last have the following? CHOLESTEROL TEST:_____ RESULTS:_____

TETANUS SHOT:_____

WOMEN ONLY: Last Pap Smear:_____ Have you ever had an abnormal result? YES NO

FAMILY HISTORY

Have any of your blood relatives had any of the following? (Please list relationship)

High Blood Pressure: _____

Heart Attack: include age_____

_____

Stroke:_____

Cancer:_____

_____

Diabetes:_____

Thyroid Disease:_____

Glaucoma:_____

Emotional/Nervous Problems:_____

_____

PAST MEDICAL HISTORY

Please list Hospitalizations or Surgeries (please include psychiatric)

DATE OR AGE	REASON
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Serious Injuries:_____

HABITS AND SOCIAL HISTORY

Many of these questions are personal. Discuss any you hesitate to answer with your healthcare provider.

- Do you currently smoke or use tobacco products? YES NO
  If no, did you ever smoke or use tobacco products in the past? NO YES How long and when quit?
  _____
- Do you drink? No Yes Wine Beer Liquor How many per week?_____
- Do you have current problems with drug abuse YES NO Past? YES NO
- How many times per week do you exercise?_____ Type:_____

WESTERN WAKE WELLNESS