MRN: ______________________ CSN: ______________________

PATIENT HISTORY QUESTIONNAIRE

Adult form

Full Name *(Last, First, M.I.):* ❑ M ❑ F	**Age:**
Name you prefer to be called:	**Date of Birth:**
Previous doctor:	**Last time you were at this doctor's office:**
Why are you seeing the doctor today?	

HEALTH HISTORY

List any medical problems you have, plus year of diagnosis:	

Have you had any surgeries? ❑ No ❑ Yes

Surgery	Reason for surgery	Do you know the Hospital and Date of surgery?

Have you ever been in the hospital? ❑ No ❑ Yes

If yes, what for:

Most recent ER visit, including date and reason for visit:

Any childhood illnesses?: ❑ No ❑ Yes

Have you ever had a blood transfusion? ❑ No ❑ Yes

Do you know if you are up to date on shots? ❑ No ❑ Yes ❑ I don't know

Are you allergic to anything (medicine, foods, pollens, etc): ❑ No ❑ Yes

List all medicines you take (including prescribed drugs and over-the-counter drugs, such as vitamins, inhalers, cough medicines, Tylenol, ibuprofen, etc)

Name the Drug	How often it is given	Name the Drug	How often it is given
1.		2.	
3.		4.	
5.		6.	
7.		8.	

Please turn to the next page

MRN: ______________________ CSN: ______________________

What medical problems are in your family? (include mother and father, also siblings)

SOCIAL HISTORY

Lifestyle	**Are you:** ❑Married ❑Single ❑Divorced ❑Widowed ❑ In a relationship			**Are you sexually active?** ❑Yes ❑No
	Are there any smokers in your home? ❑ Yes ❑ No			
	Do you smoke? ❑ No ❑ Yes	**What do you smoke?** ❑ Cigarettes ❑ Cigars ❑ Pipe		
	How many do you smoke a day?	**How many years** have you been **smoking?**		
	Do you use: ❑ chewing tobacco ❑ snuff			
	Do you drink: ❑ Beer ❑ Wine ❑ Liquor	**How many drinks a day?**	**How many years?**	
	Have you used? ❑Marijuana ❑Cocaine ❑Meth ❑K2 ❑Bath Salts ❑Crank ❑Other illegal drugs			
	Have you ever **injected drugs into your body?** ❑No ❑Yes			
	Last time you saw a **dentist?**			
	Last time you saw an **eye doctor?**			
	What **pets** are in the home?			
	Have you ever been to a psychiatry facility or Juvenile detention center or Jail? ❑Yes ❑ No			
	If yes, where and when?			
Stressors Do you have any life stress?	❑ Marriage problems	❑ Money problems	❑ Legal problems	❑ Problems with your children
	❑ Insurance problems	❑ Alcohol	❑ Drugs	❑ Abuse
	❑ Job problems	❑ Mental problems	❑ Housing issue	
School & Work	Did you finish **high school?** ❑ Yes ❑ No			
	Have you **completed any college?** ❑ Yes ❑ No	Did you **graduate from college?** ❑ Yes ❑ No		
	Do you currently have a **job?** ❑ Yes ❑ No	If so, where do you work?		
Diet	**Do you eat 3 meals a day?** ❑ Yes ❑ No			
	How many **vegetables** do you eat in one day? ❑ 1 ❑ 2-3 ❑ 4-5 ❑ 6			
	How many **fruits** do you eat in one day? ❑ 1 ❑ 2-3 ❑ 4-5 ❑ 6			
	How many times a week do you eat **fast food?** ❑ 1 ❑ 2-3 ❑ 4-5 ❑ 6-7 ❑8-9 ❑greater than 10			
	What do you **drink?** ❑ Water ❑ Juice ❑ Coffee ❑ Soda ❑Energy Drinks ❑ Milk ❑Kool-aid ❑Tea			
	Are you on a **special diet?** ❑ No ❑ Yes	If yes, what is it?		

Exercise and Activities	**Do you exercise weekly?** ❑ No ❑ 1 hour ❑ 2-3 hours ❑ 4-5 hours ❑ more than 6 hours
	What are your favorite activities?
	Do you watch TV? ❑ Yes ❑ No
	If yes, how many hours a day? ❑ 1 hour ❑ 2-3 hours ❑ 4-5 hours ❑ more than 6 hours

MRN: ______________________ CSN: ______________________

OTHER

Check if you have problems, or have had, any symptoms in the following areas and briefly explain.

❑ Skin	❑ Eyes	❑ Ears	❑ Nose	❑ Throat	❑ Teeth	❑ Lungs	❑ Heart	❑ Stomach/Intestines
❑Kidneys	❑Overly Stressed	❑ Bladder	❑ Bones	❑ Muscles	❑ Joints	❑ Blood	❑ Brain	For Men: ❑ Male Issues
For Women: ❑ Period Problems	Age of first period:	How many pregnancies:	Last Pap:	Birth control you use:	Last period:			

Do you have any of the following:
❑ Advanced Directive
❑ Medical Power of Attorney
❑ Living Will

List any additional information you feel would be helpful for your doctor to know

Thank you for completing this form. It will help your doctor care for you more effectively!