

**Rappahannock Family Physicians**  
**Confidential Adult Health History Questionnaire**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PAST MEDICAL HISTORY**

List any operations or surgeries:

List any hospitalizations or serious injuries:

Date Description

Date Description

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**CURRENT HEALTH STATUS**

Please rate your general state of health (i.e. excellent, good, fair, poor): \_\_\_\_\_

List all current prescription and non-prescription medications:

Name

Dose

Name

Dose

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**Diet, exercise and Sleep Patterns**

How many hours per day do you regularly sleep? \_\_\_\_\_

Do you follow a special diet? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

What is your current weight? \_\_\_\_\_ Desired weight? \_\_\_\_\_ What did you weigh 1 year ago? \_\_\_\_\_

Do you exercise regularly? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what type of exercise and how often? \_\_\_\_\_

**Substance Use – Tobacco**

Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, check one: cigarettes \_\_\_\_\_ cigars \_\_\_\_\_ pipe \_\_\_\_\_

How many per day do you smoke? \_\_\_\_\_ For how many years have you smoked? \_\_\_\_\_

Have you quit smoking? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when? \_\_\_\_\_

Do you use chewing tobacco? Yes \_\_\_\_\_ No \_\_\_\_\_

**Substance Use – Alcohol**

Do you drink beer, wine, or alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much do you drink per week? \_\_\_\_\_

Have you ever had a problem with your drinking? Yes \_\_\_\_\_ No \_\_\_\_\_

**Substance Use – Illegal Drugs**

Do you use any illegal drugs? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what do you use? \_\_\_\_\_

Do you think you have a drug problem? Yes \_\_\_\_\_ No \_\_\_\_\_

**Safety Issues**

Do you always wear a seatbelt? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have a gun in your home? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, is it secure away from children? \_\_\_\_\_

Do you feel safe in your home? Yes \_\_\_\_\_ No \_\_\_\_\_

**PLEASE COMPLETE PAGE 2**

