Rappahannock Family Physicians

Adult Health History Questionnaire (ages 13 and up)

Today's Date: ______________

Name:	**DOB:**	**Age:**
Nickname:	☐ **Male** ☐ **Female**	

Personal Health History

Past Medical History and Family History – Please check all that may apply for you and/or family member

	You	Family Member and Who		You	Family Member and Who
Alcohol Abuse			Heart Disease		
Allergic Rhinitis			Hepatitis C Infection		
Alzheimer's Disease			Hyperlipidemia (cholesterol)		
Anemia (Iron Deficiency)			Hypertension		
Anxiety Disorder			Insomnia		
Arthritis (Osteoarthritis)			Irritable Bowel Syndrome (IBS)		
Arthritis (Rheumatoid)			Kidney Disease		
Asthma			Kidney Stones		
ADD / ADHD			Macular Degeneration		
Bipolar Disorder			Meningitis		
BPH (enlarged prostate)			Menopausal Synd.		
Cancer – Breast			Migraine/Headaches		
Cancer – Lung			Sleep Apnea		
Cancer – Prostate			Obesity		
Cancer – Colon			Osteoporosis		
Cancer – Other			Pacemaker		
COPD / Emphysema			Parkinson's Disease		
Coronary Artery Disease			Peripheral Vascular Disease		
Chrohn's /Ulcerative Colitis			Post Gastric Bypass		
Deep Vein Thrombosis (DVT)			Pulmonary Embolism		
Depression			Rosacea		
Diabetes Mellitus, Type II			Seizure Disorder		
Diabetes Mellitus, Type I			Skin Disease		
Drug Abuse			Stroke ☐TIA ("mini stroke")		
Emphysema			Thyroid d/o – hypothyroid		
Erectile Dysfunction			Thyroid d/o – hyperthyroid		
Fibromyalgia			Tobacco Abuse		
Gallstones			Tuberculosis		
Gastritis / Esophagitis			Other:		
GERD (reflux)			Other:		
Glaucoma			Other:		
Gout			Other:		
Hearing Loss (formal diagnosis)			Other:		
Heart Attack			Other:		

Patient Name ___________________________________ **DOB:**_____________________

Past Surgeries & Hospitalizations		
Month/Year	**Surgery / Reason for Hospitalization**	**Which Hospital**

Medications (including over the counter medications as well as herbal)			
Medication Name	**Strength**	**Frequency**	**Reason for Medication**

Allergies (list any medical, food and/or environmental allergies)			
Medication/Allergen	**What was your reaction?**	**Medication/Allergen**	**What was your reaction?**

Social History		
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Living Together	
Are You Employed	**If Yes, what is your profession?**	**Retired?** ☐ Yes ☐ No
Are you disabled?	☐ Yes ☐ No	
Highest level of Education?	☐ Did not graduate HS ☐ High School / GED ☐ Some College ☐ College ☐ Post-Graduate	
Religious Preference?		
Who Lives at Home?		
Have you been in the Military?		**If so, every stationed overseas?**

Health Habits and Safety:			
Exercise & Weight	Current Weight:	Desired Weight:	Weight 1 Year Ago:
	Exercise Regularly? ☐ Yes ☐No	What type:	How Often:
	Do you Follow a Special Diet? ☐ No ☐ Yes, explain:		
Sleep	How many Hours do you sleep:		
Tobacco:	Do you currently use tobacco? ☐ No ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Chewing Tobacco		
	How many packs per day:	Age when you started tobacco:	
	Are you a **former** smoker who has quit? ☐ No ☐ Yes	When did you quit:	
	If a non-smoker, are you exposed to second hand smoke? ☐ No ☐ Yes		
Alcohol:	How much alcohol do you drink in 1 week:		
	What do you drink?:		
	Are you concerned about how much you drink? ☐ Yes ☐ No	Have others expressed concern? ☐ Yes ☐No	
Drugs	Do you currently use any recreational / street drugs? ☐ No ☐ Yes. *If so, What drug:*		
	Do you currently, or have you ever, used drugs through a needle (IV drug use): ☐ No ☐ Yes		

Patient Name ______________________________ **DOB:**____________________

	Do you feel you have a drug problem? ☐ Yes ☐ No
Safety:	Do you feel safe at home? ☐ Yes ☐ No
	Do you always wear a seat belt? ☐ Yes ☐ No
	Is there a firearm in your home? ☐ Yes ☐ No — If yes, is it secured from children? ☐ Yes ☐ No

Health Maintenance	
Men & Women:	
When was your last PHYSICAL:	**When was your last CHOLESTEROL check:**
When was your last COLONOSCOPY:	**When was your last BONE DENSITY**
When was your last PNEUMONIA VACCINE:	**Do you get FLU SHOTS:** ☐ Yes ☐ No
Have you had Hepatitis B Vaccine: ☐ Yes ☐ No	**When was your last TETANUS (Td or TDaP):**
What birth control do you use:	**What sexually transmitted diseases have you had:**
Women Only & Reproductive Health:	
Age when periods started:	**Are your periods regular?** ☐ Yes ☐ No
How many days apart:	**How many days do your periods last:**
How is your flow? ☐ Light ☐ Medium ☐ Heavy	**How is your cramping?** ☐ Mild ☐ Moderate ☐ Severe
When was your last **Pap Smear**:	**What were the pap results?** ☐ Normal ☐ Abnormal
When was your last **Mammogram:**	**Do you do monthly self-breast exams?** ☐ Yes ☐ No

Total Pregnancies:	Full Term:	Premature:	Miscarriages:	Abortions

Men Only & Reproductive Health:	
Do you have problems with impotence ☐ Yes ☐ No	**Are there any sexual concerns:** ☐ Yes ☐ No
Do you have a prostate problem? ☐ Yes ☐ No	**Do you perform self-testicular exams?** ☐ Yes ☐ No
How many children do you have personally?	

Care Team (your specialists)			
Specialist:	**Their specialty**	**Specialist**	**Their Specialty**

Patient Signature: ____

Parent/Guardian Name (if patient is under 18 years):____

Parent/Guardian Signature: ____

Relationship to Patient: ____

Reviewed by Nurse or Provider: ____