LABEL

TRI-CITY HealthCenter
Our Community. Your Health.

ADULT HEALTH HISTORY QUESTIONNAIRE

Reason for Visit: List in order of importance to you	**Medicines:** List all meds, herbs, vitamins, nutritional supplements	**Allergies:** List any allergies to medications and/or foods

Past Medical History:

Do you have, or have you ever had in the past, any of the following conditions? Check (✓) YES or NO; no straight lines please. Complete both columns.

	NO	YES	COMMENTS		NO	YES	COMMENTS
High blood pressure				Kidney / Urine problems			
High cholesterol				Stroke			
Diabetes				Cancer			Specify:
Heart problem Chest pain				Prostate problems			
Thyroid problems				Arthritis / Joint problems			
Lung problems / asthma				Back problems			
Breast problems				Serious injuries			
Eye / visual problems			△ Corrective lenses	Severe headaches			
Ear / hearing problems				Convulsions / seizures			
Seasonal allergies				Anxiety / nervousness			
Stomach problems / ulcers				Blood clots (leg / lung)			
Hepatitis / liver problems				Skin problems			
Bowel problems / colon polyp				Depression			
Hemorrhoids				Other issues (please list)			
Anemia / blood problems				Surgeries			
Blood transfusions							

Surgeries and Hospitalizations:

YEAR	ILLNESS / INJURY / SURGERY	HOSPITAL

Females Only

Age of first period?
First day of last NORMAL period (LNMP):
Length of cycle? _____ Days of flow? _____
Periods are: ☐ Regular ☐ Irregular
Maximum # pads / tampons used in 1 hour? _____
Menstrual cramps: ☐ None ☐ Mild ☐ Moderate ☐ Severe
Date of last Pap Smear: _____ Was it normal? ☐ Yes ☐ No
Ever had an abnormal Pap Smear? ☐ Yes ☐ No
Date of last Mammogram: _____
Was it normal? ☐ Yes ☐ No
Did your mother take DEC (a hormone) when she was pregnant with you?
☐ Yes ☐ No ☐Unknown

Reproductive History

Have you ever been pregnant? ☐ No ☐ Yes
Total number of pregnancies: _____
a) # live births: d) # still births:
b) # full term: e) # miscarriages / abortions:
c) # premature: f) # ectopic / tubal pregnancies:

Last Delivery Date: _____ Any problems? ☐ Yes ☐ No
Number of children living? _____
Are you breastfeeding now? ☐ Yes ☐ No

Symptoms

Do you currently have any of the following symptoms? Please complete BOTH columns.
Check (✓) YES or NO; no straight lines please. Complete both columns.

	NO (-)	YES (✓)	COMMENTS		NO (-)	YES (✓)	COMMENTS
Unusual heartbeat				Problems / pain with sex			
Chest pains				Trouble sleeping			
Night sweats				Little interest / pleasure doing things?			
Trouble breathing				Feeling down, depressed, hopeless?			
Frequent cough				Very often feel moody, agitated			
Indigestion				Overwhelmed			
Constipation / diarrhea				Has anyone hurt or abused you? ☐ Never ☐ Recently ☐ In the past			
Trouble with urination				If yes, how? ☐ Physically ☐ Mentally ☐Sexually ☐ Verbal			
Blood in stools / rectum				Do you currently feel sale at home? ☐ Yes ☐ No ☐ Sometimes			
Unusual weight gain/ loss				Have you ever been placed in a girls / boys home, foster home, group home? ☐ Yes ☐ No History of domestic violence? ☐ Yes ☐ No			
Lightheaded / dizzy / faint abdominal pain				Have you ever been convicted of a sexual offense? ☐ Yes ☐ No			
Female-hot flashes							

Family History:

Have any of your family / blood relatives ever had any of the following conditions? Complete BOTH columns.

	NO (-)	YES (✓)	COMMENTS		NO (-)	YES (✓)	COMMENTS
High blood pressure				Gastrointestinal problem			
Diabetes or high sugar				Hepatitis / liver problem			
Heart problems				Alcohol / drug problem			
Stroke				Psychiatric / emotional problem			
Cancer				Inherited disorders			
TB or lung problems				Thalassemia or sickle cell			
Kidney or urine problems				Any other problems in the family?			

Habits

Do you need assistance for *daily activities?* ☐ No ☐ Yes If yes, please check from the following needs:
☐ Cooking ☐ Grocery Shopping ☐ Dressing ☐ Bed ☐ Using toilet ☐ Getting up from chair ☐Taking medication

Do you *now* use, **or have you ever used,** the following:
Tobacco ☐ Yes ☐ No Type? _____ # Packs/day: _____ # years _____ Age started: _____ years
Alcohol Use: Age started: ____ years. Sought treatment for alcohol abuse: ☐ Yes ☐ No
Involved in rehabilitation program i.e., 12 step program? ☐ Yes ☐ No Family history of alcoholism: ☐ Yes ☐ No

Drug Use / Abuse
Use drugs? ☐ Yes ☐ No ☐ Formerly Type of drug? _____ Frequency _____
Type of drug? _____ Frequency _____
Type of drug? _____ Frequency _____
Sought treatment for drug abuse: ☐ Yes ☐ No
Involved in a rehabilitation program i.e., 12 step program ☐ Yes ☐ No
Family history of drug abuse: ☐ Yes ☐ No

Sexual History

☐ No sexual experience ever before ☐ Virgin (no previous intercourse) ☐ Not sexually active at this time
☐ Sexually active with (check all that apply): ☐ Men ☐ Women ☐Both
Number of current partners: _____ Number of lifetime partners: _____
Most recent sexual relations was _____ days / months / years ago
Practice safe sex: ☐ Yes ☐ No ☐ Sometimes Most recent unprotected encounter: _____ weeks / months / years ago
Does your sexual partner have other sexual partners? ☐ No ☐ Yes ☐ I don't know / maybe
Have you had a sexual partner who has sex with: ☐ an IV drug user ☐prostitute / paid for sex ☐ person of the same sex
Have you OR your sexual partner(s) had any infections related to sex? ☐ No ☐ Yes (If yes., please specify):
History of STI's: ☐ Chlamydia ☐ Gonorrhea ☐ Genital warts ☐ Herpes ☐ Other (specify):

Birth Control Methods

How important is it for you to avoid pregnancy now? ☐ Very ☐ Somewhat ☐ Not at all
Are you and/or your partner panning to get pregnant in the next two years? ☐ Yes ☐ No ☐ Maybe
Would you like any information on how to plan for a healthy pregnancy? ☐ Yes ☐ No
What method of birth control are you using currently? ☐ None ☐ Condoms ☐ Pills ☐ Injection ☐ IUD ☐ tubal ligation ☐ Other:
Have any birth control methods cause you problems? ☐ No ☐ Yes, explain:
What birth control method have you used in the past? (Check all that apply)
Men answer the first line, women any that apply.

☐None ☐ Abstinence ☐ Rhythm method ☐ Withdrawal ☐ Condom ☐ Vasectomy

☐Pill ☐ Patch ☐ DMPA (Depo) ☐ Norplant ☐ Diaphragm ☐ IUD
☐Tubal Ligation ☐ Foam / vaginal insert ☐ Other (specify): _____

Exercise

Do you exercise regularly? ☐ No ☐ Yes If yes, what type? _____ How many minutes per session? _____

Diet

Do you have, or have you ever had, an eating disorder or special eating problems? ☐ No ☐ Yes, explain

Current Dietary Intake:	**High**	**Medium**	**Low**	**Comments:**
Fat	☐	☐	☐	
Fiber (Fruit / Vegetables)	☐	☐	☐	
Caffeine	☐	☐	☐	
Salt	☐	☐	☐	
Sugar	☐	☐	☐	
Water / Fluids	☐	☐	☐	

Immunizations & Tests

What vaccinations do you know you have received in the past *as an adult or child?* (Please check)

☐ Td / Tetanus ☐ Polio ☐ MMR ☐ Rubella ☐ Pneumovax
☐ Influenza ☐ Hepatitis A ☐ Hepatitis B ☐ Varicella
☐ Check here if you received your childhood vaccinations in the U.S.
☐ Check here if you have NOT had any vaccinations

Most recent TB skin test? _____

Have you ever had a positive TB skin test? ☐ No ☐ Yes If yes, Chest x-ray result: ☐ Normal ☐ Abnormal
Have you ever been treated for TB? ☐ No ☐ Yes
If yes, please answer the following:
Date of treatment: _____ Name of medication: _____ Length of treatment: _____ months