SOUTHERN DOMINION HEALTH SYSTEM
ADULT HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*			☐ M ☐ F	**DOB:**
Marital status:	☐ Single	☐ Partnered	☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Who referred you to our office?			**Today's Date:**	

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles	☐ Mumps	☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates:	☐ Tetanus ☐ unsure	☐ Pneumonia ☐ unsure	☐ HPV ☐ unsure	
	☐ Hepatitis B ☐ unsure	☐ Chickenpox ☐ unsure	☐ Hepatitis A ☐ unsure	
	☐ Influenza ☐ unsure	☐ MMR *Measles, Mumps, Rubella* ☐ unsure	☐ Shingles ☐ unsure	

List any medical problems that other doctors have diagnosed

☐ Allergies
☐ Anemia
☐ Anxiety/Depression
☐ Blood clots/ Pulmonary Embolism
☐ Cancer
☐ Coronary Artery Disease/ Heart Disease
☐ Diabetes --- Insulin Dependent
☐ Diabetes --- Not on Insulin
☐ COPD/Emphysema/Asthma
☐ GERD/reflux
☐ Gout
☐ Hypertension (High Blood Pressure)
☐ High Cholesterol
☐ Kidney Disease
☐ Liver Disease
☐ Osteoporosis
☐ Seizures
☐ Sleep Apnea
☐ Stroke
☐ Thyroid Disorder

List any other medical problems that other doctors have diagnosed that are not listed above:

_____

_____

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Social History

Are you currently employed? ☐ yes ☐ no If yes: what is your occupation? _____

If no: are you: ☐ a full-time parent ☐ a full-time student ☐ retired ☐ disabled

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

HEALTH HABITS AND PERSONAL SAFETY						
ALL QUESTIONS IN THIS SECTION ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL						
Exercise	☐ Sedentary (No exercise)	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?		How many drinks per day?			
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
Tobacco/ VAPE	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks. /day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit	☐ Vape			
Marijuana	Do you smoke marijuana?				☐ Yes	☐ No
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No
	Do you have any concerns regarding sexual activity you would like to discuss with your provider today?				☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	If you do not live alone, who lives with you?					
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?				☐ Yes	☐ No
	Would you like information on the preparation of an Advance Directive or Living Will?				☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Do you have any concerns regarding abuse or your personal safety?				☐ Yes	☐ No

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
In the past two weeks have you been bothered by little interest or pleasure in doing things?	☐ Yes	☐ No
In the past two weeks have you felt down, depressed or hopeless?	☐ Yes	☐ No

HEALTH MAINTENANCE		
Have you had a test for blood in your stool in the past year?	☐ Yes	☐ No
Have you ever had a colonoscopy? ☐ Yes (if yes- approximate date of last colonoscopy? _____) ☐ No		
Have you ever had an eye exam? ☐ Yes (if yes- approximate date of last eye exam? _____) ☐ No		
Are you currently seeing a dentist?	☐ Yes	☐ No
Do you currently see any other physicians for any other medical or psychiatric issues? If yes- please list names of other doctors: _____	☐ Yes	☐ No

WOMEN ONLY		
Age at onset of menstruation: Date of last menstruation:		
What is the approximate date of your last PAP smear?		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
MEN ONLY		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS		
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.		
☐ Skin	☐ Chest/Heart	☐ Recent Change in weight
☐ Head/Neck	☐ Back	☐ Recent Change in energy level
☐ Ears	☐ Intestinal	☐ Difficulties sleeping
☐ Nose	☐ Bladder	☐ Bowel
☐ Throat	☐ Lungs	☐ Circulation

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____