**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:** |

**List any medical problems that other doctors have diagnosed**

☐ Allergies
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Blood clots/Deep Vein Thrombosis/Pulmonary Embolism
☐ Cancer (Circle Type):
Lung Prostate
Colon Endometrial (uterine)
Breast Ovarian
Cervical Other (please list): _____
☐ Coronary Artery Disease/ Heart Disease
☐ Depression
☐ Diabetes --- Insulin Dependent
☐ Diabetes --- Not on Insulin
☐ COPD/Emphysema
☐ Asthma
☐ GERD/reflux
☐ Gout
☐ Hypertension (High Blood Pressure)
☐ High Cholesterol
☐ Insomnia (Sleep Difficulty)
☐ Kidney Disease
☐ Liver Disease
☐ Osteoporosis
☐ Seizures
☐ Sleep Apnea
☐ Stroke
☐ Thyroid Disorder

List any other medical problems (including mental health problems) that are not listed above:

_____

_____

_____

**Surgeries**

| Year | Reason | Hospital |
|---|---|---|
| | | |
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**Other hospitalizations**

| Year | Reason | Hospital |
|---|---|---|
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## Social History

### Occupational History

If you are currently employed, what is your occupation? _____

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

### Educational History

What is the highest level of education you achieved? ☐ Elementary School ☐ Middle School

☐ Some High School ☐ High School Diploma ☐ G.E.D. ☐ Technical or Trade School (after High School)

☐ Some College ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree

☐ Professional/Doctoral Degree (PhD, MD/DO, JD or similar) ☐ Other _____

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

| Name the Drug | Strength | Frequency Taken |
|---|---|---|
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**Allergies to medications** (please list the reaction you had – rash, swelling, difficulty breathing, vomiting, etc.)

| Name of the Drug | Reaction You Had | Name of the Drug | Reaction You Had |
|---|---|---|---|
| | | | |
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## FAMILY HEALTH HISTORY

Please list any relevant family health problems, including (but not limited to) cancer, diabetes, high blood pressure, high cholesterol, kidney disease, thyroid disease, and mental health problems (anxiety, depression, bipolar disorder, schizophrenia) or mark if your family history is unknown.

☐ **I WAS ADOPTED** ☐ **FAMILY HISTORY UNKNOWN**

| | AGE | HEALTH PROBLEMS | | AGE | 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** | | | | | | |
| **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 – #packs per day _____ | | ☐ Chew | ☐ Pipe | ☐ Cigars | |
| | ☐ # 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: | | | | | |
| | Illness related to sexually transmitted diseases and the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this include unprotected sexual intercourse. Would you like to speak with your provider about your risk? | | | | ☐ 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 |
| | Do you feel safe in your home? | | | | ☐ Yes | ☐ No |
| | Do you feel socially isolated? | | | | ☐ Yes | ☐ No |
| | Are you exposed to crime either at home, at work, or in your community? | | | | ☐ Yes | ☐ No |
| | Is your current housing situation secure, or are you at risk of losing your housing? | | | | ☐ Yes | ☐ No |
| | Do you have sufficient access to food? | | | | ☐ 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 |

| ACTIVITIES OF DAILY LIVING | | | | | | |
|---|---|---|---|---|---|---|
| **Can you perform the following basic tasks of daily life?** | | | | | | |
| Bathing/Grooming (personal hygiene) | ☐ | Independent | ☐ | Need some help | ☐ | Total assistance required |
| Dressing and Undressing | ☐ | Independent | ☐ | Need some help | ☐ | Total assistance required |
| Transferring (movement, walking, standing or sitting up) | ☐ | Independent | ☐ | Need some help | ☐ | Total assistance required |
| Toileting | ☐ | Independent | ☐ | Need some help | ☐ | Total assistance required |
| Eating (feeding, using utensils) | ☐ | Independent | ☐ | Need some help | ☐ | Total assistance required |
| Shopping | ☐ | Independent | ☐ | Need some help | ☐ | Total assistance required |
| Cooking | ☐ | Independent | ☐ | Need some help | ☐ | Total assistance required |
| Managing Medications | ☐ | Independent | ☐ | Need some help | ☐ | Total assistance required |
| Managing Personal Finances | ☐ | Independent | ☐ | Need some help | ☐ | Total assistance required |
| Doing Housework (Cleaning, Tidying, Laundry) | ☐ | Independent | ☐ | Need some help | ☐ | Total assistance required |
| Using the telephone or other communication (email, texting) | ☐ | Independent | ☐ | Need some help | ☐ | Total assistance required |
| Driving or using Public Transportation | ☐ | Independent | ☐ | Need some help | ☐ | Total assistance required |

| CONTINUITY OF CARE | | |
|---|---|---|
| Do you see any other providers for medical or mental health care? | ☐ Yes (please list below) | ☐ No |
| Name: | Practice Name/Facility: | Contact Information: |
| | | |
| | | |
| | | |

| 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 | | |
| Have you seen a dentist in the past year? ☐ Yes ☐ No ☐ I would like a dental referral | | |

| WOMEN ONLY | | |
|---|---|---|
| Age at onset of menstruation: Age when menstruation stopped: Date of last menstruation (first day): | | |
| **What is the approximate date of your last PAP smear?** | | |
| Total number of pregnancies: _____<br>Number of Full-term births: _____ Pre-term births: _____ Miscarriage/Terminations: _____ Living Children: _____ | | |
| Are you pregnant or breastfeeding? | ☐ Yes | ☐ No |
| Have you had a ☐ Dilation and Curettage (D&C) ☐ Hysterectomy ☐ Cesarean-section (how many? # _____) | | |
| **MEN ONLY** | | |
| **Date of last prostate and rectal exam?** | ☐ Yes | ☐ No |
| **Date of last PSA test (if done)?** _____ | | |

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____