Family Care Health Centers Adult Medicine Questionnaire

Social Security No.:	Date:	Patient Name:		Date of Birth:						
Prior Physician(s): Marital Status: Single Married Divorced Separated Widow/er Religion (optional): Social Security No: Employer's Name: Employer's Address: Spouse's Phone#: W) FAMILY HISTORY MOTHER FAMILY HISTORY FAMILY HISTORY Mother Mother	·		Phone#: (H)	Work#:						
Social Security No:										
Employer's Name:										
Employer's Address: Spouse's Phone# H)		cial Security No.: Maiden Name (if applicable):								
Spouse's Phone: Hone: Hone	Employer's Name:		Occupat	ion:						
Spouse's Phone: Hone: Hone	Employer's Address	:								
MOTHER Is your mother alive? Yes No	Spouse's Phone#: H		Emergency (Contact Name:						
MOTHER Is your mother alive? Yes No How old is she?	W	")	Relationship	Relationship: Phone:						
MOTHER Is your mother alive? Yes No How old is she?			FAMILY HISTO	RY						
If deceased, what age and what did she die from? Does/did she have serious health problems during life?	MOTHER									
If deceased, what age and what did she die from? Does/did she have serious health problems during life?	Is your mother alive	? □Yes □No		How ol	d is she?					
FATHER Syour father alive? Yes										
Is your father alive? Yes No	Does/did she have se	erious health problems during lif	e?							
Is your father alive? Yes No	EARNED									
If deceased, what age and what did he die from? Does/did he have serious health problems during life? IS THERE A HISTORY IN YOUR FAMILY OF? Diabetes Premature Heart Attack or Bypass Migraine Headaches Ovarian Cancer Heigh Blood Pressure Bleeding Disorders Breast Cancer Bleeding Disorders Breast Cancer MEDICAL HISTORY List ongoing chronic medical problems List any and all surgeries or hospitalizations you have had with approximate dates: List all medications (with dosage and frequency) you take (include Tylenol, Aspirin, Birth Control Pills etc.) List any medications you are allergic to: Last Tetanus Booster Injection: Last Tuberculosis Skin Testing: Last Tuberculosis Skin Testing: Last Tuberculosis Skin Testing: Cast Pneumovax Injection: HAVE YOU EVER HAD THE FOLLOWING? Measles Anemia Hepatitis Chicken Pox Asthma High Cholesterol Mono Pneumomia Radiation treatment to tonsils or adenoids Response: To other Adult Vaccinations: Response: Positive Response: Posi				** 1	11.1.0					
Does/did he have serious health problems during life? STHERE A HISTORY IN YOUR FAMILY OF? Diabetes										
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Diabetes	Does/did ne nave sei	nous nearth problems during me	· · · · · · · · · · · · · · · · · · ·							
High Blood Pressure	IS THERE A HIST	ORY IN YOUR FAMILY OF	?							
Bleeding Disorders	□Diabetes	□Premature Hea	rt Attack or Bypass	☐Migraine Headaches	□Ovarian Cancer					
Ulcerative or Crohn's Disease Colon Cancer	☐High Blood Pressu	re (Before age 5	(5)	☐ Asthma or Allergies	□Prostate Cancer					
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Last Pneumovax Injection:Other Adult Vaccinations: HAVE YOU EVER HAD THE FOLLOWING? Measles					—————————————————————————————————————					
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□Diabetes □Sickle cell anemia □Cancer		□A psychiatric p								
	□Diabetes	- · ·		•						
LITE OF OR PRODUCT OF OTHER PRODUCT OF THE PRODUCT	☐High blood pressur			IV/Aids						

		PERSO	ONAL HISTORY		
Physical Condition:	ramilarly?	□Ves □No		If Ves doing	what?
Do you exercise regularly? □Yes Current Weight			Weight 2 years ago?		
Tobacco:					
Do you smoke o	r chew tobacco?		No Have you evaluated:		
Alcohol:					
Have people and Have you felt ba	elt you ought to cur noyed you by critic id or guilty about y ad a drink first thir	izing your drinkin our drinking?	g? □Y □Y	es □No es □No	over/eye opener? □Yes □N
Drugs : Do you smoke n	narijuana?	□Yes □No	Use illicit drugs?	□Yes □No	
Sexual: Have you ever h Sexual Preference	ad a sexually trans ce: □Hetero	mitted disease? sexual (straight)	□Yes □N □Homosexu		
Date of onset me	od: ad an abnormal pa enopause: self-breast exam?	p smear?	☐Yes ☐No Me Date of last		of last Pap Smear:l:
DO YOU CURRENTLY	Y HAVE PROBLI	EMS WITH?			
☐Severe Headaches	☐Shortness of Br		□Severe Indigestion/	Heartburn	☐Back Pain
□Abdominal Pain	☐Heart Palpitation	ns	□Diarrhea		□Arthritis
☐Recurrent Nosebleeds	□Depression		□Constipation		□Skin Rashes
□Ringing in Ears	□Insomnia		□Pains in legs while	walking/rest	□Hives
□Dizziness	□Nervousness or	Anxiety	☐Black, Tar-like Sto	ols	□Chest Pains
□Difficulty Swallowing □Chronic Cough			☐Frequent Urination		□Wheezing
□Phlebitis/Blood Clots □Blood in Urine			□Coughing Up Blood ution		□Blood in Stool
o you wear glasses □Yes □No ate of last eye exam?		How is How is	How is your eyesight (with glasses)? How is your hearing?		
How many pillows do you sleep on? Do you wake up at night to urinate? □Yes □No			Do you wake up at night short of breath? If Yes, how often?		⊔Yes ⊔No
Patient Signature					Date
Provider S	Signature				Review Date(s)