Date: _____

In your opinion, what are your most important health problems: 1. _____

2. _____ 3. _____

You are: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

You live with: ☐ Spouse ☐ Parents ☐ Relatives ☐ Friend ☐ Alone ☐ Other

I. HEALTH MAINTENANCE:

1. Do you exercise at least 3 times a week? ☐ Yes ☐ No
2. Do you see a dentist on a regular basis? ☐ Yes ☐ No
3. Do you see an eye doctor on a regular basis? ☐ Yes ☐ No
4. What is your usual occupation? _____
5. WOMEN ONLY: A. Do you perform breast self-examination monthly? ☐ Yes ☐ No
   B. When was your last mammogram? _____
   C. When was your last pap smear? _____

II. HEALTH HABITS:

1. Do you currently smoke cigarettes: ☐ Yes ☐ No
   How many per day? _____ How long? _____
2. If you are an ex-smoker, how long ago did you stop smoking? _____
3. On the average, how many drinks do you have per day? _____
   (one drink = one 12 oz. beer, one 4 oz. glass of wine or one 1 oz. shot of whiskey)
4. Have you ever tried to cut down on drinking? ☐ Yes ☐ No
5. Have you ever been annoyed by criticism about drinking? ☐ Yes ☐ No
6. On the average, how much of the following beverages do you consume per day?
   Coffee: _____ Colas: _____ Tea: _____
7. Have you ever used "street" drugs? ☐ Yes ☐ No
8. Do you wear a seat belt when traveling in a car? ☐ Yes ☐ No

III. PREVIOUS SURGERIES AND HOSPITALIZATION: _____

_____

_____

_____

IV. ALLERGIES: _____

V. FAMILY AND PERSONAL HEALTH HISTORY:

Please indicate by X's which of the following problems you or any blood relative have had.

	SELF	PARENT SIBLING CHILDREN		SELF	PARENT SIBLING CHILDREN
Cancer	☐	☐	Hemophillia/Sickle Cell/Thalassemia	☐	☐
Chronic Infection (eg-Tb)	☐	☐	High Cholesterol	☐	☐
Congenital Abnormalities	☐	☐	Hypertension	☐	☐
Diabetes	☐	☐	Lung Disease	☐	☐
Heart Disease	☐	☐	Strokes	☐	☐
Other: _____				☐	☐

PIONEER MEDICAL GROUP

ADULT HEALTH HISTORY QUESTIONNAIRE / HEALTH ASSESSMENT

ADDRESSOGRAPH / LABEL

PT. NAME: _____

DOB: _____ FC: _____

MR#: _____ CHB: _____

PHYSICIAN: _____ PHY#: _____

SPECIALTY: _____

DATE: _____ LOC: _____

Patient Name:_____ M.R. #:_____

I. GENERAL:
In the past year, have you had:
An unexplained weight gain or loss of 10 lbs or more . . . . . ☐ Yes ☐ No

II. EYES, EARS, NOSE, THROAT:
In the past year, have you had:
1. Failing Vision . . . . . ☐ Yes ☐ No
2. Trouble with your hearing . . . . . ☐ Yes ☐ No
3. Persistent hoarseness . . . . . ☐ Yes ☐ No

Have you ever had:
4. A temporary loss of vision in one or both eyes . . . . . ☐ Yes ☐ No

III. RESPIRATORY:
In the past year, have you:
1. Coughed up blood . . . . . ☐ Yes ☐ No
2. Had shortness of breath which interfered with your normal functions . . . . . ☐ Yes ☐ No
3. Had a recurrent cough . . . . . ☐ Yes ☐ No

IV. CARDIOVASCULAR:
In the past year, have you had:
1. Repeated bothersome chest pain or discomfort with exercise or stress . . . . . ☐ Yes ☐ No
2. Shortness of breath if you lie flat . . . . . ☐ Yes ☐ No
3. Swollen (not just puffy) ankles or feet . . . . . ☐ Yes ☐ No
4. Painful leg cramps brought on by walking which stopped immediately with rest . . . . . ☐ Yes ☐ No

V. GASTROINTESTINAL:
In the past year, have you had:
1. Recent difficulty or pain in swallowing . . . . . ☐ Yes ☐ No
2. Frequent episodes of vomiting . . . . . ☐ Yes ☐ No
3. Persistent changes in bowel habits . . . . . ☐ Yes ☐ No
4. Any bloody or black stools . . . . . ☐ Yes ☐ No
5. A recent loss of appetite . . . . . ☐ Yes ☐ No

VI. GENITOURINARY / SEXUAL HISTORY:
In the past year, have you had:
1. Persistent trouble passing urine . . . . . ☐ Yes ☐ No
2. Bloody urine . . . . . ☐ Yes ☐ No
3. To get up more often than twice a night to urinate . . . . . ☐ Yes ☐ No
4. An unsatisfactory sex life . . . . . ☐ Yes ☐ No

Have you ever had:
5. Infections of the kidney or bladder (more than 3 / year) . . . . . ☐ Yes ☐ No
6. Treatment for sexually transmitted diseases . . . . . ☐ Yes ☐ No
7. Sexually Active . . . . . ☐ Yes ☐ No
8. Multiple Sexual Partners . . . . . ☐ Yes ☐ No
9. Sexual Partner Male . . . . . ☐ Yes ☐ No
10. Sexual Partner Female . . . . . ☐ Yes ☐ No

VII. GENITOURINARY (MEN ONLY):
In the past year, have you had:
1. A discharge from your penis . . . . . ☐ Yes ☐ No
2. A lump or swelling of your testicle . . . . . ☐ Yes ☐ No
3. Impotence / Erectile Dysfunction . . . . . ☐ Yes ☐ No

VIII. OBSTETRICS / GYNECOLOGY (WOMEN ONLY):
In the past year, have you had:
1. Repeated pain with intercourse . . . . . ☐ Yes ☐ No
2. Gone six or more months without a period . . . ☐ Yes ☐ No
3. Vaginal spotting or bleeding in between periods . . . . . ☐ Yes ☐ No
4. Birth control: ☐ pills ☐ IUD ☐ abstinence ☐ Depo Provera ☐ diaphragm ☐ surgery ☐ none
5. If you have been in the menopause, have you had vaginal bleeding or spotting in past year . . . . . ☐ Yes ☐ No
6. Have you had abnormal pap within the last year . . . . . ☐ Yes ☐ No

IX. SKIN / BREAST:
In the past year, have you had:
1. A persistent skin rash or problem . . . . . ☐ Yes ☐ No
2. Moles or skin lumps that have changed either size or color . . . . . ☐ Yes ☐ No
3. Lumps or soreness in the breast or nipple . . . ☐ Yes ☐ No
4. Any nipple discharge . . . . . ☐ Yes ☐ No

X. MUSCULOSKELETAL:
In the past year, have you had:
1. Joint pain or swelling without injury . . . . . ☐ Yes ☐ No
2. Limited ability to move a joint . . . . . ☐ Yes ☐ No

XI. NEUROLOGY:
In the past year, have you had:
1. A change in your headache pattern for worse ☐ Yes ☐ No
2. Troublesome double vision . . . . . ☐ Yes ☐ No
3. Lost your ability to speak clearly for a few minutes . . . . . ☐ Yes ☐ No
4. Recurrent numbness or weakness over any part of your body . . . . . ☐ Yes ☐ No

XII. PSYCHOLOGICAL:
In the past year, have you:
1. Had difficulty falling asleep or frequent awakening . . . . . ☐ Yes ☐ No
2. Found that you sleep more than usual for you . . . . . ☐ Yes ☐ No
3. Felt depressed or blue most of the time . . . . ☐ Yes ☐ No
4. Have crying spells . . . . . ☐ Yes ☐ No
5. Often wished you were dead . . . . . ☐ Yes ☐ No
6. Had Panic Attacks . . . . . ☐ Yes ☐ No
7. Are there any other issues that you wish to discuss with me?
   Concerning yourself? . . . . . ☐ Yes ☐ No
   Concerning your family? . . . . . ☐ Yes ☐ No

Have you ever:
1. Attempted suicide . . . . . ☐ Yes ☐ No
2. Been hospitalized for problems with your nerves . . . . . ☐ Yes ☐ No
3. Been seen by a psychiatrist, psychologist or counselor for personal problems . . . . . ☐ Yes ☐ No

PATIENT SIGNATURE _____ DATE _____ PHYSICIAN SIGNATURE _____ DATE _____