NOVANT HEALTH

Adult History Questionnaire

Date: _____

Name: _____ **DOB:** _____ **Age:** _____

Referring Physician: _____ Primary Care Physician: _____

Chief Complaint: _____

Past Medical History

Past Surgical History

Please list allergies of any kind, and include reactions: _____

Present Medications (Please include all prescription and non-prescription medications.)

Name	Dose	Name	Dose
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Obstetrical History # of Pregnancies _____ # of Children: _____ Age at first live birth: _____
Age of menarche: _____ Age of menopause: _____

Social History/Habits Tobacco: Y / N _____ Type _____ Times per day _____
Exercise: Y/N _____ Times per wk _____ Caffeine: _____
Alcohol: Y/N _____ Times per wk _____ Street Drugs: Y/N _____

FAMILY HISTORY:

		If Living			If Deceased	
Relationship	*Age*	*Health*			*Age at Death*	*Cause*
Father		☐ Good	☐ Fair	☐ Poor		
Mother		☐ Good	☐ Fair	☐ Poor		
Brother/Sisters		☐ Good	☐ Fair	☐ Poor		
M / F		☐ Good	☐ Fair	☐ Poor		
M / F		☐ Good	☐ Fair	☐ Poor		
M / F		☐ Good	☐ Fair	☐ Poor		
M / F		☐ Good	☐ Fair	☐ Poor		
M / F		☐ Good	☐ Fair	☐ Poor		

Check if any blood relatives (mother, father, brother, sister, aunt, uncle, grandfather, grandmother) have had any of the following:

	YES	NO		YES	NO		YES	NO
Stroke			Epilepsy			Colitis		
Cancer			Emphysema			Rheumatic Heart		
High Blood Pressure			Bleeding Tendency			Congenital Heart		
Tuberculosis			Heart Attack			Died Suddenly		
Diabetes			Kidney Disease			Heart Failure		
Leukemia			Arthritis					

NOVANT HEALTH

Adult History Questionnaire

Name: _____ **DOB:** _____

Please check indicating if you have or have had problems with any of the following and describe in the space provided.

GENERAL HEALTH	YES	NO	COMMENTS
Fever	☐	☐	
Chills	☐	☐	
Fatigue or tiredness	☐	☐	
Cancer	☐	☐	
Unexplained weight gain or loss	☐	☐	
EYES			
Disease/Injury	☐	☐	
Blurred Vision	☐	☐	
Double Vision	☐	☐	
Glaucoma	☐	☐	
EARS/NOSE/MOUTH/THROAT			
Hearing Loss	☐	☐	
Ringing in the Ears	☐	☐	
Earaches/Drainage	☐	☐	
Nosebleeds	☐	☐	
Chronic Sinus Problems	☐	☐	
Mouth Sores	☐	☐	
Sore Throat	☐	☐	
Voice Changes	☐	☐	
Swollen Neck Glands	☐	☐	
CARDIOVASCULAR			
Heart Trouble	☐	☐	
Chest Pain/Angina	☐	☐	
Rheumatic Fever	☐	☐	
Irregular or fast heartbeat	☐	☐	
High Blood Pressure	☐	☐	
Swelling of Feet/Hands	☐	☐	
RESPIRATORY			
Shortness of Breath	☐	☐	
Coughing	☐	☐	
Spitting up Blood	☐	☐	
Asthma/Wheezing	☐	☐	
GASTROINTESTINAL			
Change in Bowel Movements	☐	☐	
Nausea/Vomiting	☐	☐	
Frequent Diarrhea	☐	☐	
Rectal Bleeding/Blood in Stool	☐	☐	
Abdominal Pain/Heartburn	☐	☐	
Peptic or Stomach Ulcers	☐	☐	
Colitis	☐	☐	
Gallbladder disease	☐	☐	
GENITOURINARY			
Frequent Urination	☐	☐	
Burning/Painful Urination	☐	☐	
Blood in Urine	☐	☐	
Incontinence or Dribbling	☐	☐	
Kidney Stones	☐	☐	
Sexual Difficulty	☐	☐	
Male – Testicle Pain	☐	☐	
Female – Irregular Periods	☐	☐	
Female - Planning pregnancy	☐	☐	
Females - Menopause	☐	☐	
Sexually Transmitted Disease	☐	☐	
MUSCULOSKELETAL			
Joint Pain	☐	☐	
Muscle Pain	☐	☐	
Muscle Weakness	☐	☐	
Joint Stiffness/Cramping	☐	☐	
Gout	☐	☐	
Arthritis	☐	☐	
SKIN/BREAST			
Rash or Itching	☐	☐	
Change in Skin Color	☐	☐	
Change in Hair/Nail Color	☐	☐	
Varicose Veins	☐	☐	
Breast Pain	☐	☐	
Female – Breast Discharge	☐	☐	
NEUROLOGICAL			
Stroke	☐	☐	
Frequent Headaches	☐	☐	
Lightheadedness/Dizziness	☐	☐	
Seizures	☐	☐	
Numbness/Tingling	☐	☐	
Tremors	☐	☐	
Head injury	☐	☐	
Blackout/Loss of Consciousness	☐	☐	
PSYCHIATRIC			
Nervousness	☐	☐	
Depression	☐	☐	
Insomnia	☐	☐	
ENDOCRINE			
Hormone Problem	☐	☐	
Thyroid Disease	☐	☐	
Diabetes	☐	☐	
Excessive Thirst	☐	☐	
Excessive Urination	☐	☐	
Heat/Cold Intolerance	☐	☐	
Dry Skin	☐	☐	
HEMATOLOGY/LYMPHATIC			
Slow to Heal After Cuts	☐	☐	
Bleeding or Bruising Tendency	☐	☐	
Anemia	☐	☐	
Past Transfusions	☐	☐	
Enlarged Glands	☐	☐	
Jaundice	☐	☐	
Hepatitis	☐	☐	
ALLERGIC/IMMUNOLOGIC			
Food Allergies	☐	☐	
Environmental Allergies	☐	☐	
Latex Allergies	☐	☐	

Reviewed by: _____ Initials / Date _____ _____ Initials / Date _____