Family Practice Physicians
10301 Glacier Highway
Juneau, Alaska 99801
Phone 789-2910

Name _____

Date _____

Who Referred You? _____

ADULT HISTORY QUESTIONNAIRE

This questionnaire is designed to help the doctor to do a thorough and relevant exam. It will become a part of your medical record and is therefore a strictly confidential matter between you and your doctor. Please answer the questions as well as possible. If any question seems irrelevant simply leave it blank.

PAST HEALTH

1. What illnesses did you have as a child? _____

_____

2. Please check if you have ever had any of these illnesses.

☐ Rheumatic fever	☐ Tuberculosis	☐ Diabetes
☐ Glaucoma	☐ Arthritis	☐ Anemia
☐ Ulcers	☐ Kidney or Bladder Infection	☐ Cancer
☐ Nervous or Mental Illness	☐ Heart Trouble	☐ High Blood Pressure
☐ Syphilis or Gonorrhea		☐ Chronic Diarrhea

Other Serious Illness_____

3. Operations:____

Month & Year	Type	Name of Hospital	City & State

4. Hospitalizations other than surgery?____

Month & Year	Reason	Name of Hospital	City & State

5. Serious Injuries?____ Broken Bones?____ Please Describe _____

_____

6. Taking any medication or other treatments?____ (incl. aspirin, antacid, birth control pills)

Medication	How often	Reason

7. Allergies?____ Reactions to penicillin or other medicines?____ Foods? Other? _____
Describe _____

8. Cigarette smoking?____ How much? ____per day?____ Age began smoking _____
Stopped smoking _____ When? _____

9. Alcohol use?____ How much? _____

10. Change in weight?_____ loss_____ gain_____ Usual weight_____ Weight at age 20_____

11. Please place a check (✓) beside exams and immunizations you have had and if you can, give the year you last had them.

Year	Test
	Physical Exam
	Chest X-Ray
	TB skin test
	Electrocardiogram
	Other X-Rays
	Blood Transfusion

Year	Immunizations
	Tetanus Shot
	Diptheria
	Polio Vaccine
	Measles
	German Measles
	Mumps
	Flu

SYMPTOM LIST

PLACE A CHECK (✓) in front of any of the following body parts or symptoms that <u>are</u> problems for you. Cirlce the specific problems you are <u>most</u> concerned about.

(A) ☐ Rashes, color change
☐ Itching, brusing
☐ Warts, moles, lumps, hives
☐ Skin trouble, eczema
☐ Excessive sweating
☐ Bleeding, anemia
☐ Gland swelling

(B) ☐ Head injury, concussion
☐ Headaches, migraine
☐ Dizziness, fainting
☐ Ear trouble, infection
☐ Hearing loss, noises
☐ Vision loss, double vision
☐ Glasses, difficulty reading
☐ Nosebleeds, stuffy nose
☐ Sinus trouble, hayfever
☐ Sore throats, hoarseness
☐ Dental problems, gums
☐ Goiter, thyroid problem

(C) ☐ Enlargement, painful breasts
☐ Lumps, discharge from breasts

(D) ☐ Shortness of breath
☐ Cough, chest colds
☐ Bringing up sputum or blood
☐ Wheezing, asthma
☐ Chest pain, pleurisy
☐ Exposure to tuberculosis
☐ Fevers, sweats, chills

(E) ☐ Chest pain, tightness, pressure
☐ Fast or irregular heart beat
☐ Trouble breathing when lying down
☐ Waking short of breath
☐ Swelling of feet or ankles
☐ Previous heart trouble, murmurs
☐ High blood pressure
☐ Poor circulation, varicose veins
☐ Blood clots

(F) ☐ Pain or burning on urination
☐ Trouble starting or stopping urination
☐ Blood or pus in urine
☐ Frequent urinating
☐ Sores or discharge

(G) ☐ Trouble swallowing
☐ Poor appetite
☐ Gas, cramps, pains
☐ Heartburn, indigestion
☐ Nausea, vomiting
☐ Constipation, diarrhea
☐ Blood in stool, hemorrhoids
☐ Yellow jaundice, hernia

(H) ☐ Pains in joints, arthritis
☐ Back pain, neck pain
☐ Swollen or red joints, stiffness

(I) ☐ Convulsions, fits, spells
☐ Shaking, weakness, tremor
☐ Numbness, tingling, paralysis
☐ Difficulty walking, coordination
☐ Depression, anxiety
☐ Poor sleeping
☐ Nervousness, tension
☐ Trouble thinking, remembering
☐ Crying, upset, worrying
☐ Sexual problems
☐ Birth control – Type _____

FOR WOMEN ONLY:

(J) ☐ Irregular or frequent periods
☐ Excessive flow or spotting
☐ Painful periods
☐ Vaginal discharge or itching
Number of pregnancies _____
Number of miscarriages _____ Abortions _____
Number of living children _____
Date of last period _____
Date of last cancer smear (PAP) _____
Blood type _____

FAMILY HISTORY

1. Please fill in the following list for your parents, brothers and sisters. List brothers and sisters in **order of birth**.

RELATION	NAME	YEAR BORN	WHERE LIVING	Health Problems or Cause & Date of Death
Mother				
Father				

2. Please fill in the following list of your immediate family (children and spouse) if applicable. List children in order of birth.

RELATION	NAME	YEAR BORN	LIVING AT HOME? If not, where?	Health Problems or Cause & Date of Death
Spouse				
Children				

3. Please list all the people who live in your house if not listed above. (e.g. grandparents, foster children, friends, etc.)

RELATION	NAME	YEAR BORN	HEALTH PROBLEMS

4. Check any of these diseases that have occurred in your family and list who has had it. Includes Aunts, Uncles, and Cousins as well as close family.

❑ Diabetes_____

❑ High Blood Pressure_____

❑ Anemia_____

❑ Bleeding Disorder_____

❑ Epilepsy_____

❑ Ulcers_____

❑ Arthritis_____

❑ Allergy, Asthma_____

❑ Birth Defects_____

❑ Heart Trouble_____

❑ Stroke_____

❑ Cancer_____

❑ Tuberculosis_____

❑ Obesity_____

❑ Suicide_____

❑ Mental Illness_____

❑ Glaucoma_____

❑ Other_____

PERSONAL HISTORY (Used to assess health risks)

1. Where and when were you born?_____
2. What is your marital situation?_____
3. What is your job?_____

   Briefly describe the type of work you do, hours of work, and for whom_____

   _____

   _____
4. What does your spouse do?_____
5. What is your religious preference?_____
6. How much formal education have you received?_____
7. Where have you lived?_____

   _____

   _____
8. Where and when have you traveled out of the U.S.?_____

   _____

   _____
9. When did you come to Juneau?_____
10. Do you know how to swim?_____ Do you have a boat?_____ Fly a plane?_____
11. Do you use car seat belts? ❑ Always ❑ Seldom ❑ Never
12. Activity: (Check one or more boxes)

    1. ❑ Sedentary life with little exercise
    2. ❑ Mild exercise with job, house or recreation (climb stairs, walk over 3 blocks, golf, bowl, etc.)
    3. ❑ Occasional vigorous activity with work or recreation
    4. ❑ Regular vigorous exercise program or hard work
13. Any hobby or avocation?_____
14. Are there any major changes planned in the near future?_____

    _____

    _____

    _____
15. Please describe anything else about your present or past health not previously noted.

    _____

    _____

    _____

    _____