

ADULT PHYSICAL HEALTH QUESTIONNAIRE

Please update any changes that have occurred in the last year.

Name: _____ Today's Date: _____ Date of Birth: _____

Changes in Medications?
 Yes No

(New medications prescribed since your last visit or changes in dosage. Please list any medications that you are taking including over-the-counter medications, vitamins, laxatives and herbal supplements.)

Medication Name:	Dose:	Taken How/How Often?	Who Prescribed This?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies?
 Yes No

Allergy: _____

Reaction: _____

Allergy: _____

Reaction: _____

Past Medical and Surgical History: (Please list most recent first)

Surgery	Year	Hospitalization	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Your Specialists:

(Please list those you currently see or have seen)

Name	Specialty	Name	Specialty
_____	_____	_____	_____
_____	_____	_____	_____

Immediate Family History: (Please note the following diseases: Cancer, Diabetes, High Blood Pressure, Heart Trouble, Stroke, Seizures, Thyroid Disorder, Mental Disorders, Asthma, Osteoporosis, Tuberculosis.)

Family:	Age (if living)	Deceased: (note age and cause)	Healthy or noted Illness(es):	Additional Siblings with age and condition:
Father:	_____	_____	_____	_____
Mother:	_____	_____	_____	_____
Brother:	_____	_____	_____	_____
Sister:	_____	_____	_____	_____
Son:	_____	_____	_____	_____
Daughter:	_____	_____	_____	_____

Please check if you have written additional information on the back of the page.

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Name: _____ Today's Date: _____ Date of Birth: _____

Social History

Preferred Language: _____ Need Interpreter? Yes No
 Currently Employed: Yes No Retired
 Occupation: _____ Hours worked per week: _____
 Is your work satisfying and free from undue pressure or stresses? Yes No
 Do you miss much time from work? Yes No

Marital Status: Single Married Separated Divorced Widowed
 # of Previous Marriages: _____
 How is your relationship with your spouse? _____
 Is your sex life satisfying? Yes No
 How is your relationship with your children? _____
 Number of Children: _____ Girls _____ Boys
 Do you give or receive ongoing care at home? Yes No To or from whom? _____
 Do you have an advanced directive? Yes No
 Does this office have a copy on file? Yes No

Smoking: Never Yes, # of Packs/Day: _____
 Former # of Years Smoked: _____
Alcohol: Never Yes, # of Drinks/Week: _____
 Former Type: _____
Illicit Drugs: Never Yes
 Former Type: _____
Caffeine Intake: Yes No
 Coffee Tea Soda Energy Drink Chocolate Daily Intake: _____
Lifestyle: Are you on a specific diet? Yes No If yes, which type of diet? _____
 Do you exercise regularly? Yes No If yes, what type of exercise: _____
 Number of days per week: _____
 Hours per day: _____

Preventive Care: (please give date of last exam)

Exams:	Date:	Screenings:	Date:	Vaccines:	Date:	Other	Date:
Physical Exam	_____	Diabetic Screen	_____	Tdap	_____	Female Only:	
Dental Exam	_____	Lipid Panel	_____	Gardasil	_____	Pap Smear	_____
Eye Exam	_____	Colonoscopy	_____	Hep A	_____	Mammography	_____
EKG	_____	Bone Density	_____	Hep B	_____		
		TB Test	_____	Influenza	_____	Male Only:	
Diabetics Only:		STD Testing	_____	Pneumonia	_____	PSA	_____
Hemoglobin A1C	_____			Zostavax (shingles)	_____		
Urine Micro Alb	_____						
Foot Exam	_____						

Do you take aspirin 81mg daily? Yes No

Please check if you have written additional information on the back of the page.

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**Please mark any of the following conditions that you may have on a recurrent basis.
Answer all questions that apply.**

General:

- Fatigue
- Fever
- Chills or night sweats
- Weight gain
- Weight loss

Head, Eyes, Ears, Nose, Throat:

- Eye pain or injury
- Itching or eye redness
- Vision: Loss/Blurry/Double

- Ear pain or discharge
- Hearing loss
- Ringing in ears/Tinnitus
- Dizziness
- Fainting spells

- Bleeding nose
- Runny nose/sneezing/itching
- Sinus pressure

- Bleeding gums
- Sore Throat
- Painful swallowing

Neck:

- Stiffness or injury
- Enlarged glands

Respiratory:

- Wheezing
- Difficulty breathing
- Frequent colds
- Chronic or frequent cough
- Bloody sputum
- Asthma
- Seasonal or environmental allergies

Cardiovascular:

- Chest pain
- Chest pressure
- Heart murmur
- Palpitations / Heart skips
- Shortness of breath w/ exercise
- Shortness of breath lying down
- Leg cramps or swelling
- Varicose veins

Gastrointestinal:

- Loss of appetite
- Abdominal pain or cramping
- Heartburn or indigestion
- Intolerance to greasy /spicy food
- Vomiting food
- Vomiting blood
- Constipation
- Diarrhea
- Nausea
- Pain with bowel movements
- Blood in stool or black stool
- Hemorrhoids

Genitourinary:

- Burning or painful urination
- Blood in urine
- Urine frequency or urgency
- Loss of urine w/ cough or sneeze
- Decrease in strength of stream
- Nighttime urination:
- # of times _____

Gynecological (Women Only):

- Vaginal discharge
- Pain with menstruation
- Pain with sexual relations
- Age when period started: _____
- How long do periods last? _____ days
- Are periods regular: Yes No
- Age at menopause: _____
- Number of pregnancies: _____
- Number of miscarriages: _____
- Number of abortions: _____
- Number of children: _____
- Do you take Folic Acid? Yes No

Locomotor-Musculoskeletal:

- Pain in neck or back
- Joint pain or swelling
- Muscle pain or weakness
- Difficulty walking
- Balance problems
- Pain while walking

Neuro-Psychiatric:

- Seizures Convulsions
- Tremors
- Extremity numbness, tingling
- Problems with balance or gait
- Memory problems
- Headaches or migraines
- Trouble sleeping Insomnia
- Anxiety
- Depression
- Suicidal thoughts
- Loss of interest
- Hallucinations

Hematologic:

- Excessive bleeding
- Abnormal bruising
- Slow to heal after cuts

Skin:

- Frequent infections or boils
- Hives/eczema/rash
- Moles that are changing
- Skin Cancer:
 - Basal cell / Squamous cell
 - Melanoma
- Keloids
- Skin allergies:
 - Latex or Tape
 - Other: _____

Endocrine:

- Hormone therapy
- Hot Flashes
- Hot or cold intolerance
- Excessive thirst
- Change in texture hair or skin

Male Reproductive:

- Erectile Dysfunction
- Testicular pain or mass
- Penile discharge

Date _____

Patient Signature _____

Provider Signature _____

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Depression Screening Test (PHQ-9)

Over the last two weeks, how often have you been bothered by any of the following problems?

(Please circle the number to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or over eating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people notice. Or the opposite – being so fidgety or restless that you have to move around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Add columns: (Add totals for the 3 columns)		+	+	
			Total	=

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not at all
 Somewhat difficult
 Very difficult
 Extremely difficult

Alcohol Screening Test

Please mark your answer. Points are posted next to your answer. Add up total at bottom of section.

1. **How often do you have a drink containing alcohol?**
 Never (0.0) Monthly or less (0.5) 2-4 times a month (1.0) 2-3 times a week (1.5) 4 or more times a week (2.0)
2. **How many drinks containing alcohol do you have on a typical day when you are drinking?**
 1 or 2 (0.0) (0.5) 3 or 4 (1.0) 5 or 6 (1.5) 7 to 9 (2.0) 10 or more
3. **Have people annoyed you by criticizing your drinking?**
 No (0.0) Yes (1.0)
4. **Have you ever felt bad or guilty about your drinking?**
 No (0.0) Yes (1.0)
5. **Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?**
 No (0.0) Yes (1.0)

Score: _____ A score of 2.5 or greater indicates possible misuse and the need for further evaluation. Please fill out the Alcohol Audit Form.

PROVIDER INITIALS _____