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? ______________________________

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

☐ Rheumatic fever
☐ Glaucoma
☐ Ulcers
☐ Nervous or Mental Illness
☐ Syphilis or Gonorrhea
☐ Tuberculosis
☐ Arthritis
☐ Kidney or Bladder Infection
☐ Heart Trouble
☐ Diabetes
☐ Anemia
☐ Cancer
☐ High Blood Pressure
☐ 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 are problems for you. Cirlce the specific problems you are most 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?____________________

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   ____

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?____________________

    ____

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    ____

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

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