WENTWORTH HEALTH PARTNERS

ADULT HEALTH QUESTIONNAIRE

Name:_____ **DOB:**_____ **AGE:**_____ **Sex:** □M □F

Who was your previous primary care provider? _____

What is your preferred Pharmacy? _____

Preferred language? Written_____ Spoken_____

Are you currently active in a religious community? □ Yes □ No
Religious Affiliation: _____

Education: What is the highest level of education you have completed?:
□ Grammar school □ High school or equivalent □ Some college
□ Bachelor's degree □ Masters degree □ Doctoral degree □ Other_____

Employment: Are you currently employed? □ Yes □ No If yes, Employer: _____

Occupation: _____ History of hazardous work conditions (i.e. asbestos etc.) Type: _____

CURRENT MEDICATIONS (may bring own list to visit if you prefer)

Name of Medication	Strength of Medication	Dosing Instructions
Example: Tylenol	*Example: 500 mg*	*Example: 1 pill three times a day*

* Note – this information may be taken directly from the pharmacy label on prescription products

ALLERGIES

□ No Known Allergies □ Medication Allergies □ Environmental/Seasonal Allergies □ Latex Allergy

List Allergies	Reaction

PAST MEDICAL HISTORY (Check all that apply)

□ Acid Reflux/GERD
□ ADHD
□ Alcoholism
□ Allergies
□ Anemia
□ Anxiety
□ Arthritis
□ Asthma
□ Bleeding Disorders
□ Cancer
□ Depression
□ Diabetes
□ Emphysema/Bronchitis/COPD
□ Epilepsy/Seizure Disorder
□ Glaucoma/Cataracts
□ Headaches
□ Hearing Loss
□ Heart Disease
□ High Blood Pressure
□ High Cholesterol
□ Irritable Bowel
□ Kidney Disease
□ Liver Disease
□ Osteoporosis
□ Stroke
□ Thyroid Disease
□ Chronic Pain
□ Other (please list) - _____

PAST SURGICAL HISTORY

Date of Surgery (Operations)	Type of Surgery (Operations)

FAMILY HISTORY (Check all that apply)

□ Asthma □ Dementia/Alzheimer's □ Depression □ Diabetes
□ Heart Disease □ High Blood Pressure □ High Cholesterol □ Thyroid Disease
□ Stroke □ Cancer (please specify) -_____
□ Other (please list) - _____

GYN HISTORY

Number of Pregnancies: _____ Number of Living Children: _____

SOCIAL HISTORY

Personal History

Marital Status □ Single □ Significant Other □ Married □ Divorced □ Widowed
Name of Significant Other/Spouse if applicable:_____
Children: □ Yes □ No Number of Sons_____ Number of Daughters_____
Name and Ages of Children: _____
Living Situation: □ Live Alone □ With Significant Other/Spouse □ With Children/Family Members □ Other
Occupation: _____
Hobbies/Interests: _____

Tobacco

Have you ever smoked? □ Yes □ No If yes, what do you (did you) smoke? _____
Are you still smoking? □ Yes □ No

If no: How many years ago did You quit? _____ For how many years did you smoke? _____ How many packs/day did you smoke? _____

If yes: How many years have you smoked? _____ How many packs/day do you smoke? _____
Have you ever tried to quit? _____

Alcohol

Do you drink alcohol including beer, wine, or other alcohol? ☐ Yes ☐ No
If yes please specify frequency
□ Daily □ Almost Daily (4-6 times/week) □ 1-3 times per/week □ Less than one time/week

Do you drink caffeine? □ Yes □ No If yes, how many cups per day? _____

Illicit Drugs

Do you use any drugs or prescription medications not prescribed to you? □ Yes □ No
(including marijuana, cocaine, amphetamines, pain or anxiety medications, etc)
If yes please specify type of drug and frequency of use -_____

Diet/Activity

Are you on any special diet? □ Yes □ No
If yes, how would you describe your diet? (e.g. South Beach, Atkins, calorie intake, renal, diabetic, low sodium, low fat, etc.)
_____

Do you currently participate in any regular activity to improve or maintain your physical fitness (either on your own or in a formal class)? □ Yes □ No If yes, please describe:

_____

_____

Health Planning

Do you have Advanced Directives in place? □ Yes □ No

□ Living Will □ Durable Power of Attorney □ Health Care Proxy □ Advanced Directives

HEALTH MAINTENANCE

Please provide the dates and results of the following immunizations, examinations, and tests to the best of your ability. If you have not had one of these services please indicate N/A (not applicable).

All Patients:

Last Tetanus Booster	□ Within past 10 years	□ More than 10 years ago		□ Unknown
Last Eye Examination	Date: _____	□ Normal	□ Abnormal	□ Unknown
Last Hearing Exam	Date: _____	□ Normal	□ Abnormal	□ Unknown
Last sigmoidoscopy/colonoscopy/ Or stool test	Date: _____	□ Normal	□ Abnormal	□ Unknown
Last DEXA Bone Scan	Date: _____	□ Normal	□ Abnormal	□ Unknown
Last Pneumonia Vaccine	Date: _____			
Flu shot this season?	□ Yes □ No			

Women:

Last Pap Smear	Date: _____	□ Normal	□ Abnormal	□ Unknown
Last Mammogram	Date: _____	□ Normal	□ Abnormal	□ Unknown

Men:

Last Prostate Specific Antigen-PSA	Date: _____	□ Normal	□ Abnormal	□ Unknown
Last Prostate Exam	Date: _____	□ Normal	□ Abnormal	□ Unknown

CONCERNS

Please indicate any concerns regarding your health in the space provided.

_____

_____

_____

_____

_____

_____

Patient Name (printed) _____

Patient Signature:_____ **Date**_____

We would like to personally thank you for taking the time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit together.