WENTWORTH HEALTH PARTNERS

THE CARDIOVASCULAR GROUP
19 Old Rollinsford Road, Dover, NH 03820 Phone (603) 516-4265 Fax (603) 740-2713

ADULT HEALTH QUESTIONNAIRE
DEMOGRAPHICS

Patient Name: _____ DOB: ___/___ /____ Sex: ❑ M ❑ F

PAST MEDICAL HISTORY: please check all that apply.

HEART PROBLEMS

	Year	Yes	No		Year	Yes	No
Heart attack		❑	❑	High blood pressure		❑	❑
Congestive Heart Failure		❑	❑	Irregular heart beat		❑	❑
Coronary Artery Disease (CAD)		❑	❑	Other:_____		❑	❑

LUNG PROBLEMS

	Year	Yes	No		Year	Yes	No
Asthma		❑	❑	Emphysema		❑	❑
Bronchitis		❑	❑	Other:_____		❑	❑
Pneumonia							

NERVOUS SYSTEM PROBLEMS

	Year	Yes	No		Year	Yes	No
Stroke		❑	❑	Dementia		❑	❑
Parkinson's Disease		❑	❑	Alzheimer's Disease		❑	❑
Epilepsy or seizures		❑	❑	Other:_____			

OTHER HEALTH PROBLEMS

Do you have any trouble with your vision?_____ Hearing?_____

LIST SURGERIES (OPERATIONS OR HOSPITALIZATIONS)

DATE	SURGERY OR REASON FOR HOSPITALIZATION

LIST ALL MEDICATIONS THAT YOU USE (Prescription, non-prescription, natural products)

You may attach a copy of a medication list here instead of completing the grid

Name of Medication	Dosing Instructions	Strength (mg)	Date		Prescribed by:
			Start	End	

DO YOU HAVE ANY ALLERGIES: ❑ **Yes** ❑ **No**

ALLERGY TO:	REACTION:

Have any immediate family members had any of the following conditions? (Check all that might apply):
please specify maternal or paternal grandparent/aunt/uncle

	Who?	Yes	No		Who?	Yes	No
Dementia		❑	❑	Stroke (CVA)		❑	❑
Alzheimer's Disease		❑	❑	Diabetes		❑	❑
Heart Disease		❑	❑	Depression		❑	❑
High Blood Pressure (Hypertension)		❑	❑	High Cholesterol (Hyperlipidemia)		❑	❑
Kidney Disease		❑	❑	Anemia		❑	❑
Thyroid Disease		❑	❑	Other:_____			

Cancer	Type/Location	Who?	Yes	No
			❑	❑
			❑	❑
			❑	❑

LEARNING NEEDS

Is your primary language English? ❑ **Yes** / ❑ **No**

- If no, what is your primary language? _____

How do you like to learn? (Check all that apply)

❑ 1:1 conversations ❑ Small groups ❑ Reading

EDUCATION / EMPLOYMENT / MILITARY

Last year of education completed? (Check One):

❑ Elementary School	❑ Some High School	❑ High School Graduate
❑ Some College	❑ College Graduate	❑ Graduate School
❑ GED	❑ Home Schooling	❑ Post-Grad School

Are you currently working? (Check one):

❑ Retired	❑ Part Time	❑ Full Time	❑ Disabled
❑ Unemployed	❑ Laid Off	❑ Self Employed	❑ Student

What type of work do (or did) you do?_____

Were you (or are you) in the military? ❑ **Yes** / ❑ **No**

If yes, what branch?_____ How many years served?_____
Current Status (active duty, reserves, discharged, retired military)? _____
Type of discharge?_____ Noise Exposure? ❑ **Yes** / ❑ **No**
Biohazard Exposure? ❑ **Yes** / ❑ **No** Stationed Overseas? ❑ **Yes** / ❑ **No**

MARITAL STATUS / FAMILY / SOCIAL SUPPORT

Are you currently (check one)?

❑ Married	❑ Divorced	❑ Living with significant other	❑ Single, never married	❑ Widowed	❑ Legally Separated

Do you have children? ❑ **Yes** / ❑ **No**

If yes, how many? _____ Sons, _____Daughters

With whom do you live? (Check one):

❑ Alone	❑ Spouse or Partner	❑ Child	❑ Other Family Member Specify:_____	❑ Other: Specify:_____

Do you have a social network that you can depend on? ❑ **Yes** / ❑ **No**

Please specify, (e.g., church, friends, family, etc.) _____

SOCIAL HABITS

Smoking:

Have you **ever** smoked? ❑ **Yes** / ❑ **No** If no:

- Do you have passive smoke exposure? ❑ **Yes** / ❑ **No**

If yes:

- What year did you start smoking? _____
- What do/did you smoke? _____
- How many packs per day do/did you smoke? _____
- Have you ever tried to quit? ❑ **Yes** / ❑ **No**
  - Method used (acupuncture, counseling, medication, etc.)?_____
  - Longest period tobacco free? _____
- Do you still smoke? ❑ **Yes** / ❑ **No**
  - If no, what year did you quit?_____
  - How many years did you smoke? _____

Drinking:

Do you drink any alcoholic beverages? (e.g., beer, wine or other alcohol such as vodka, whiskey, gin, rum, etc.)?
❑ **Yes** / ❑ **No** Specify Type:_____ Amount:_____drinks

- How often?

❑ daily ❑ weekly ❑ monthly ❑ yearly ❑ socially

Do you drink any caffeinated beverages?
(e.g., coffee, caffeinated soda, tea, etc.) ❑ **Yes** / ❑ **No** Specify Type:_____

- If yes, how often? How many cups per day?_____

❑ Daily ❑ 4-6 times/ week ❑ 1-3 times week ❑ Less than one time/ week ❑ Never

DIET:

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:_____

RELIGION/SPIRITUALITY

Do you have a religious affiliation? ❑ **Yes** / ❑ **No**

- If yes, religion:_____ Do you practice your religion? ❑ **Yes** / ❑ **No**

Do you have any spiritual beliefs? ❑ **Yes** / ❑ **No**

Are spiritual or cultural beliefs an important part of your daily life? ❑ **Yes** / ❑ **No**

HOME & SAFETY

	Yes	No		Yes	No
Do you have smoke detectors in your home?	❑	❑	Pool/Spa in the home?	❑	❑
Do you have carbon monoxide detectors in your home?	❑	❑	Home heating source(electric, gas, oil, etc.)?_____		
Radon in the home?	❑	❑	Treated ❑ Untested ❑		

Firearms in the home?❑ **Yes** / ❑ **No**

If yes:

- Locked storage? ❑ Yes / ❑ No Trigger guard? ❑ Yes / ❑ No
- Ammunition stored separately? ❑ Yes / ❑ No Unloaded for storage? ❑ Yes / ❑ No
- Kept for: recreation ❑ hunting ❑ occupation ❑ protection ❑

Animals in the home? ❑ **Yes** / ❑ **No**

- If yes, type:_____
- Are you the individual who cleans up after the animal(s)? ❑ **Yes** / ❑ **No**

RECENT TRAVEL

Out of state? ❑ **Yes** / ❑ **No** If yes, destination:_____
Out of country? ❑ **Yes** / ❑ **No** If yes, destination:_____
Do you agree to a transfusion? ❑ **Yes** / ❑ **No**

HEALTH PLANNING

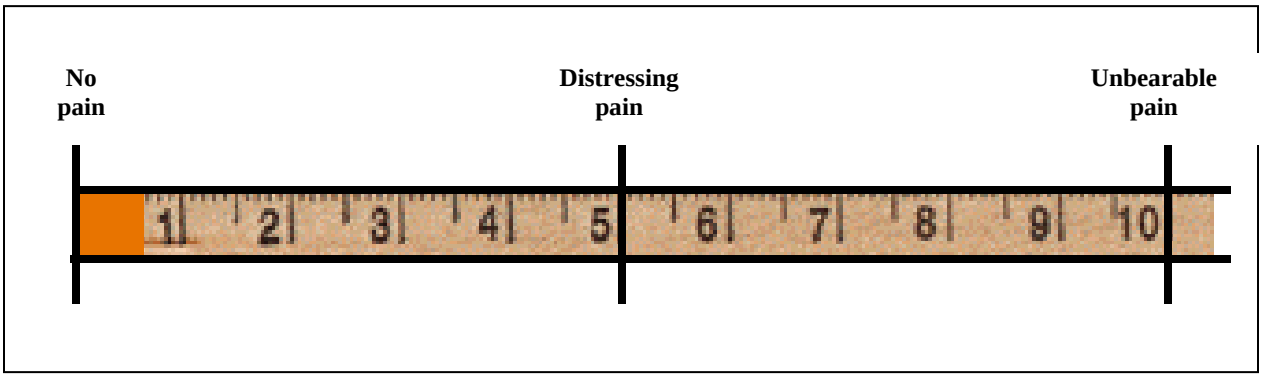
Do you have ***Advanced Directives*** in place?

❑ None ❑ Living Will ❑ Durable Power of Attorney ❑ Health Care Proxy ❑ Advanced Directives

ALL PATIENTS:

Do you experience ongoing pain? ❑ **Yes** / ❑ **No** If yes, please describe:_____
_____
_____

If yes, please circle your level of pain:



How do you relieve your pain? _____
_____
_____
_____

Patient Signature: _____ Date: _____