# Sunshine Medical Care

## Comprehensive Patient Health History Questionnaire (ADULT NEW)

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update form you can use. Please fill in all **six** pages. It is long because it is comprehensive. We really want to know you well so we can properly care for you. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it.
Thank-you!

Today's Date: ____/____/__________

Patient's Name: ______________________________ DOB: ____/____/__________

Briefly, what are you seeing the doctor about today?

________________________________________________________________________________

____________________________________________________________________________

**How would you rate your health? (circle one): Excellent / Good / Fair / Poor**

**List any medical suppliers you use (e.g. respiratory supplies, etc): __________________________**

**Are you currently taking any Medication(s)?** □ None
Please list (or show us your own printed record) **all** prescriptions and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc).

□ Check box if you brought a list of your medications (give it to my assistant and don't write in medications below):

| Medication Name: | Strength: | Directions: |
|---|---|---|
| ____________________________ | __________ | ______________________________ |
| ____________________________ | __________ | ______________________________ |
| ____________________________ | __________ | ______________________________ |
| ____________________________ | __________ | ______________________________ |
| ____________________________ | __________ | ______________________________ |
| ____________________________ | __________ | ______________________________ |
| ____________________________ | __________ | ______________________________ |

**Do you have any Allergies to any Medications?** □ No Allergy

| Allergy Name: | Type or reaction: |
|---|---|
| _________________________________ | _______________________________________ |
| _________________________________ | _______________________________________ |
| _________________________________ | _______________________________________ |
| _________________________________ | _______________________________________ |

**Pharmacy: (Required)**
Name: _______________________ Location:_______________________
Phone Number: (____) ______-__________

**Please list any Past Medical Problems:** □ None

Medical Condition: Date or Age Diagnosed:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

**Have you had any Surgeries?** □ None

Type of Surgery: Date or Age Performed:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

**Are there any known medical conditions in your Family History?** □ None

| Medical Condition: | Family member: |
|---|---|
| □ Hypertension | ______________________________ |
| □ High Cholesterol | ______________________________ |
| □ Diabetes | ______________________________ |
| □ Heart disease ( List ______________) | ______________________________ |
| □ Cancer ( List ______________) | ______________________________ |
| □ Other: ( List ______________) | ______________________________ |
| □ Other: ( List ______________) | ______________________________ |

**SOCIAL HISTORY:**

Marital Status: ________________ No. of Children: ____________________

Occupation: ____________________

**SMOKING, ALCOHOL AND RECREATIONAL DRUGS:**

Do you Smoke? □ Nonsmoker

□ Currently smoke □ Cigarettes □ Cigars □

How many pack per day, week? __________ □ How many years of smoking? ____________

□ Smoked in the past □ Date Quit: _______

How many did you smoke? __________ □ How many years did you smoke? ____________

Do you drink alcoholic beverages? □ Nondrinker

□ Socially How often? ___________________

□ Current Drinker □ Type: _______ □ How much per day, week? ___________________

□ Past Drinker □ Date Quit: _________

Do you use any recreational Drugs? □ None

□ Current Use □ Type: ____________ □ How much? __________________

□ Past Use □ Type: ____________ □ Date Quit: ___________________

**Do you have any History of Addiction or Abuse of Drugs or Medications?** □ None

If yes, Explain: ______________________________________________________________

**Do you have any History of Psychiatric Conditions?** □ None

<u>Condition:</u> <u>Date or Age Diagnosed:</u>

_______________ _______________

_______________ _______________

**Do you have any History of Communicable diseases?** □ None

<u>Condition:</u> <u>Date or Age Diagnosed:</u>

_______________ _______________

_______________ _______________

_______________ _______________

**Do you see any other Providers?** □ None

<u>Provider Name:</u> <u>Specialty:</u> <u>Phone number::</u>

_______________ _______________ _______________

_______________ _______________ _______________

_______________ _______________ _______________

**GYNECOLOGICAL HISTORY:**

Total number of pregnancies: _____ No. of births: ____ No. of miscarriages:_____ No. of abortions:______

Age at beginning of periods (menstruation): ____________________

Do you use Birth Control?: Type? _________________________

Age at end of periods (menopause/hysterectomy): _____________ □ Not applicable

If you are having periods, how often do they occur? Every _______ days. How long do they last? _____ days.

**HEALTH MAINTENANCE SCREENING TESTS:**

Last Physical (How many years ago?): ________________

Last time you had blood work? Date:__________________ Result, if known: _____________________

Colonoscopy or Sigmoidoscopy (circle one) Date:______________________ Normal? □ Yes □ No

Polyps? □ Yes □ No

Eye Exam: Most recent date ___________________________ Normal? □ Yes □ No

<u>Women only:</u>

Mammogram Most recent date ___________________________ Normal? □ Yes □ No

Pap smear Most recent date ___________________________ Normal? □ Yes □ No

Bone Density Test Most recent date ___________________________ Normal? □ Yes □ No

<u>Men only:</u>

PSA Most recent date ___________________________ Normal? □ Yes □ No

**IMMUNIZATIONS:** Enter date (if known) of any vaccinations you have had.

Tetanus (Td): _______________ With Pertussis (Tdap): ____________

Influenza (flu shot): ____________

Pneumovax (pneumonia): ______________

Varicella (Chicken Pox): _______________ □ Shot or □ Illness

MMR: _______________

Zostavax (shingles): _______________

Meningitis: ______________

Hepatitis A: _______________ Hepatitis B: _______________

HPV: __________________

**Thank-you for taking the time to complete this form!**