FirstHealth Infectious Diseases
ADULT Health History Questionnaire

Patient Name: _____ DOB: _____

Please answer the questions as accurately as you can. Please do not forget to sign this sheet of paper. Our nurses will help you with any questions when they get your vital signs.

Surgical History – List any surgeries and the date they occurred			
Type of Surgery	Date of Surgery	Type of Surgery	Date of Surgery

Medications – List your medications. Do not forget to include vitamins and/or herbal supplements			
Medication	Dose	Frequency	Date Started

Vaccines	
Date of Last Flu Shot:	Date of Last Pneumococcal Shot:
Date of Last Tetanus Shot:	Date of Last Shingles Shot:
Other:	

Allergies – List any medication allergies			
Medication Name	Type of Reaction	Medication Name	Type of Reaction

Allergies – List any food allergies			
Food Name	Type of Reaction	Food Name	Type of Reaction

Allergies – List any other allergies			
Allergen	Type of Reaction	Allergen	Type of Reaction

Past Medical History			
	Yes	No	
Is there a history of cancer?			Type:
Eyes, Ears, Nose, Mouth	Yes	No	
Eye problems			Type:
Ear, Nose, or Throat Disease			Type:
Respiratory	Yes	No	
Asthma			
Chronic Obstructive Pulmonary Disease (COPD) – Emphysema			
Other lung disease			Type:
Heart	Yes	No	
Heart attack			
Congestive Heart Failure			
Peripheral Arterial Disease			
High Blood Pressure			
Other Cardiac or Circulatory problems			Type:
Gastrointestinal	Yes	No	
Acid Reflux			
Gastrointestinal ulcers			
Pancreatitis			
Liver Disease			
Irritable Bowel Syndrome			
Inflammatory Bowel Disease			
Colon Polyps			
Other Gastrointestinal problems			Type:
Genitourinary Disease	Yes	No	
Urinary infection			
Urinary incontinence			
Other urinary problems			Type:
Orthopedics	Yes	No	
Fractures			Type:
Arthritis			Type:
Other orthopedic problems			Type:
Skin	Yes	No	
Psoriasis			
Other dermatologic disease			Type:

Past Medical History (continued)			
Neurological	Yes	No	
Stroke			
Headache/Migraines			
Seizures			
Sleep Apnea			
Other Neurologic Disease			Type:
Mental Health	Yes	No	
Anxiety			
Are you on any medication for depression?			
Bipolar			
Post Traumatic Stress Disorder			
Panic Disorder			
Other Mental Health problems			Type:
History of any Psychiatric Hospitalization			
Endocrine	Yes	No	
Diabetes			
Thyroid Disease			
Other endocrine diseases			Type:
Blood	Yes	No	
Blood Transfusion			
Unusual bleeding			
Other blood related problems			Type:
Infections	Yes	No	
HIV			
Tuberculosis			
Viral Hepatitis			
STD			
Other infections			Type:
Other	Yes	No	
Accident or injury			Type:
Any hospital stays not yet recorded?			
Do you have a history of any other health problem you have not yet recorded?			Type:

Social History		
Current Occupation: ☐ Retired		
Current Occupation Hazards:		
Cigarette or Cigar Smoking: ☐ Never ☐ Current ☐ Previous		
If Current or Previous Smoker, age when started smoking:		
Quantity smoked: ☐ 1-6 per week or less ☐ 1-5 per day ☐ 5-9 per day ☐ 0.5 to 1 PPD ☐ 1–1.5 PPD ☐ 1.5-2 PPD ☐ more than 2 PPD		
Age and date when quit:		
Chewing tobacco or snuff: ☐ None ☐ 1/day ☐ 2-4/day ☐ 5+/day		
Alcohol Use:	☐ Never ☐ No ☐ Social ☐ Regular ☐ Problem Drinking ☐ Recovery Alcoholic	If yes, choose appropriate: ☐ 1 drink a week or less ☐ 1-2 drinks a day ☐ more than 1-2 a day ☐ a lot more a day
Drug Use:	☐ Never ☐ Current If yes, type: ☐ Previous	Frequency: ☐ Occasional ☐ Weekly ☐ Daily
Sexuality:	Are you sexually active? ☐ Active ☐ Not Active ☐ Virgin Sexual Partner: ☐ Male ☐ Female ☐ Both	
Marital Status:	☐ Never Married ☐ Separated ☐ Remarried ☐ Live with significant other ☐ Divorced ☐ Married ☐ Widowed	
Children:	☐ Yes ☐ No If yes, number of children:	If yes, ages and sex of Children:
Pets: (dogs, cats, birds, etc.)		
Other household members:		
Advance Directive and/or Living Will ☐ Yes ☐ No		
Travel:		
Hobbies:		
Have you ever been in prison? If so, when:		

Family Medical History

Please list next to the individual family member any serious medical problem experienced by this person. If the family member has died, please list year, age, and cause of death.

Family Member	Diseases	Died	Date of Death, Age, and Cause
Mother		☐ Yes ☐ No	
Father		☐ Yes ☐ No	
Brother(s)		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
Sister(s)		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
Other Relation		☐ Yes ☐ No	

Men's Health

	Yes	No	
Prostate trouble			Type:
Other male genital or sexual problems			Type:

Women's Health

Date of last menstrual period:	Current Method of Birth Control:
Menses monthly: ☐ Yes ☐ No	Frequency of Cycle: Occurs every days
Duration of flow (days):	Type of Flow: ☐ Light ☐ Moderate ☐ Heavy

Please sign and date

Patient's Signature _____ Date _____

Signature of person completing this form if not patient _____ Date _____