consensushealth™

Comprehensive Adult Health History Questionnaire

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please fill in the next five 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 questions you don't have to answer it. Thank you.

Main Reason for Today's Visit: _____

Other Concerns: _____

_____

Medications: Please list (or show us your own printed record) all prescriptions and non-prescriptions medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc.)

__ Check if you do not take any prescription or over the counter medications.

__ Check if you brought a list of your medications (please give to the front desk with your paperwork)

Medications	**Dose (Mg/Mcg/Pill)**	**How Many Times Per Day**

Pharmacy Information

Pharmacy Name: _____ Phone Number: _____

Address, City, State: _____

Mail Order Pharmacy: _____

Allergies or Intolerance to Medications

_____

_____

_____

Personal Medical History: Do you have now, or have you had any of the following conditions?

Condition	Yes	Year	Comments
Alcohol/Drug abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder/Kidney Problems			
Blood Clot (leg)			
Blood Clot (lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer of the Breast			
Cancer of the Colon			
Cancer of any other type			
Cancer of the Ovarian			
Cancer of the Prostate			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema (COPD)			
Fractures			Where?
Gallbladder Disease			
Gastroesophageal Reflux (GERD/Heartburn)			
Glaucoma			
Gout			
Gynecological Conditions (endometriosis)			
Gynecological Conditions (fibroids)			
Gynecological Conditions (other)			
Heart Attack			
Hepatitis – Type A			
Hepatitis – Type B			
Hepatitis – Type C			
Hepatitis - Other			
High Blood Pressure			
High Cholesterol			

Personal Medical History Continued

Condition	Yes	Year	Comments
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease / Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate (enlargement)			
Prostate (nodules)			
Seizure / Epilepsy			
Skin Condition (eczema)			
Skin Condition (psoriasis)			
Skin Condition (abnormal moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid High (overactive) Hyperthyroidism			
Thyroid Low (underactive) Hypothyroidism			
Other (list)			
Other (list)			

Surgical & Procedure History – Please check off any procedure or surgeries. List any abnormal finding, details or complications under comments.

Surgical Procedure	Yes	Year	Comment
Abdominal Surgery			
Angiogram (heart)			
Angiogram (vascular)			
Appendectomy (appendix removal)			
Back Surgery (lumbar)			
Biopsy (location in comments)			
Breast Biopsy			Circle: Right Left Both
Breast Surgery			Circle: Right Left Both
Cataract Surgery			
Colonoscopy			
Coronary Bypass			
Coronary Stent			
C-Section			
Echocardiogram (heart)			
EGD (stomach endoscopy)			
Gallbladder Removal			Circle: Laparoscopic

Surgical & Procedure History Continued

Surgical Procedure	Yes	Year	Comment
Heart Surgery (other than coronary bypass checked above			
Hip Surgery			Circle: Right Left Both
Hysterectomy (partial, ovaries left)			Circle: Laparoscopic Vaginal Both
Hysterectomy (total, including ovaries)			Circle: Laparoscopic Vaginal Both
Knee Surgery			Circle: Right Left Both
LEEP (cervix Surgery)			
Neck (spine) Surgery			
Ovary Removal			Circle: Right Left Both
Pulmonary Function Test			
Sigmoidoscopy			
Sinus Surgery			
Stress Test (stress echo)			
Stress Test (thallium/perfusion)			
Stress Test (treadmill)			
Tonsillectomy			
Tubal Ligation			
Vasectomy			
Other (list)			

Family History

Indicate which relative has had the following diseases (parents, brothers and sisters are the most important) Write in the number of siblings in the appropriate boxes. If some siblings are alive and some are deceased use the space to the right to explain further.

	Mother	Father	Sister(s)	Brother(s)
Alive				
Deceased				
Age currently or at time of death				

Diseases & Conditions

	Mother	Father	Sister(s)	Brother(s)	List age(s) at diagnosis if known and if this was the cause of death
No significant history known					
Hypertension (high blood pressure)					
Hyperlipidemia (high cholesterol)					
Heart Attack, Angina (coronary artery disease)					

Diseases & Conditions

	Mother	Father	Sister(s)	Brother(s)	List age(s) at diagnosis if known and if this was the cause of death
Diabetes Type II (adult onset)					
Cancer Breast					
Cancer Colon					
Cancer Prostate					
Osteoporosis					
Depression					
Alcoholism/Drug Abuse					
Alzheimer's					
Asthma					
Autoimmune Disease					
Bleeding or Clotting Disorder					
Cancer, Lung					
Cancer, Ovarian					
Cancer, Other Type					
Colon Polyp					
Diabetes Type I (childhood onset)					
Emphysema (COPD)					
Genetic Disorder (explain)					
Glaucoma					
Heart Disease (CHF)					
Heart Disease (other)					
Hepatitis B or C					
Hip Fracture					
Hypothyroidism/Thyroid Disease					
Kidney Disease					
Kidney Stones					
Macular Degeneration					
Stroke					
Sudden Cardiac Death					
Other (list)					
Other (list)					

Immunizations

Influenza (flu shot) _____ Pneumovax 23 (pneumonia)_____ Prevnar 13 (pneumonia)_____
Date: _____ Date: _____ Date: _____

Colonoscopy Date:_____Year: _____ Abnormal_____ Normal_____Polyps_____

Retinal Exam Date:_____Year:_____Where: _____

Women only:

Mammogram: Most Recent date/where_____ Abnormal_____Normal_____

Pap Smear: Most Recent date/where_____Abnormal_____Normal_____

Social History:

Tobacco Use:
Non-Smoker_____Smoker_____Former Smoker_____Cigarettes_____Pipes_____Cigars_____

Current Smoker: Packs per day_____ Number of years_____

Former Smoker: Quit date_____ Approximately how many years did you smoke_____
Approximately how many packs did you smoke_____

Alcohol Use:
Do you drink alcohol? Yes_____No_____
Number of drinks per week:_____Beer_____Wine_____Liquor_____

Exercise:
Do you exercise regularly? Yes_____ No_____

Seatbelt Use:
Do you use your seatbelt consistently? Yes_____No_____

Sun Exposure: Frequent_____Occasionally_____Rarely_____Remote_____

Caffeine Use:
How much caffeine do you intake daily? Type_____ Cups_____