ADULT HISTORY FORM

PATIENT QUESTIONNAIRE

NAME _____

DATE OF EXAM _____

FAMILY HISTORY

	FATHER	MOTHER	BROTHER				SISTER				SPOUSE	CHILDREN					
			1	2	3	4	1	2	3	4		1	2	3	4	5	6
AGE (IF LIVING)																	
HEALTH (G) GOOD (B) BAD																	
CANCER																	
TUBERCULOSIS																	
DIABETES																	
HEART TROUBLE																	
HIGH BLOOD PRESSURE																	
STROKE																	
EPILEPSY																	
NERVOUS BREAKDOWN																	
ASTHMA, HIVES, HAY FEVER																	
BLOOD DISEASE																	
AGE (AT DEATH)																	
CAUSE OF DEATH																	

PERSONAL HISTORY

HAVE YOU EVER HAD . . .	NO	YES	HAVE YOU EVER HAD . . .	NO	YES	HAVE YOU EVER HAD . . .	NO	YES
☐ SCARLET FEVER ☐ SCARLATINA			☐ GONORRHEA ☐ SYPHILIS			ANY ☐ BROKEN ☐ CRACKED BONES		
DIPHTHERIA			ANEMIA			RECURRENT DISLOCATIONS		
SMALLPOX			JAUNDICE			☐ CONCUSSION ☐ HEAD INJURY		
PNEUMONIA			EPILEPSY			EVER BEEN KNOCKED UNCONSCIOUS		
PLEURISY			MIGRAINE HEADACHES			☐ FOOD ☐ CHEMICAL ☐ DRUG POISONING		
UNDULANT FEVER			TUBERCULOSIS			EXPLAIN		
☐ RHEUMATIC FEVER ☐ HEART DISEASE			DIABETES					
ST. VITUS DANCE			CANCER					
☐ ARTHRITIS ☐ RHEUMATISM			☐ HIGH ☐ LOW BLOOD PRESSURE			ANY OTHER DISEASE		
ANY ☐ BONE ☐ JOINT DISEASE			NERVOUS BREAKDOWN			EXPLAIN		
☐ NEURITIS ☐ NEURALGIA			☐ HAY FEVER ☐ ASTHMA					
☐ BURSITIS ☐ SCIATICA ☐ LUMBAGO			☐ HIVES ☐ ECZEMA					
☐ POLIO ☐ MENINGITIS			FREQUENT ☐ COLDS ☐ SORE THROAT			WEIGHT: NOW ONE YR. AGO		
BRIGHT'S DISEASE			FREQUENT ☐ INFECTIONS ☐ BOILS			MAXIMUM WHEN		

ALLERGIES

ARE YOU ALLERGIC TO . . .	NO	YES	ARE YOU ALLERGIC TO . . .	NO	YES	ARE YOU ALLERGIC TO . . .	NO	YES
☐ PENICILLIN ☐ SULFA DRUGS			ANY OTHER DRUGS			ANY FOODS		
☐ ASPIRIN ☐ CODEINE ☐ MORPHINE			EXPLAIN			EXPLAIN		
☐ MYCINS ☐ OTHER ANTIBIOTICS								
☐ TETANUS ☐ ANTITOXIN ☐ SERUMS			ADHESIVE TAPE			☐ NAIL POLISH ☐ OTHER COSMETICS		

SURGERY

HAVE YOU HAD REMOVED . . .	NO	YES	HAVE YOU HAD REMOVED . . .	NO	YES	HAVE YOU . . .	NO	YES
TONSILS			☐ OVARY ☐ OVARIES			HAD HERNIA REPAIRED		
APPENDIX			HEMORRHOIDS			HAD ANY OTHER OPERATIONS		
GALL BLADDER			EVER HAVE A TRANSFUSION			BEEN HOSPITALIZED FOR ANY ILLNESS		
UTERUS			☐ BLOOD ☐ PLASMA			EXPLAIN		

X-RAYS

EVER HAVE X-RAYS OF . . .	NO	YES	DATE	DISEASE PRESENT
CHEST				
☐ STOMACH ☐ COLON				
GALL BLADDER				
EXTREMITIES				
BACK				
OTHER				

SYSTEMS

DO YOU NOW HAVE OR HAVE YOU EVER HAD . . .	NO	YES	DO YOU NOW HAVE OR HAVE YOU EVER HAD . . .	NO	YES
ANY ☐ EYE DISEASE ☐ EYE INJURY ☐ IMPAIRED SIGHT			KIDNEY ☐ DISEASE ☐ STONES		
ANY ☐ EAR DISEASE ☐ EAR INJURY ☐ IMPAIRED HEARING			BLADDER DISEASE		
ANY TROUBLE WITH ☐ NOSE ☐ SINUSES ☐ MOUTH ☐ THROAT			BLOOD IN URINE		
FAINTING SPELLS			☐ ALBUMIN ☐ SUGAR ☐ PUS ☐ ETC. IN URINE		
CONVULSIONS			DIFFICULTY IN URINATION		
PARALYSIS			NARROWED URINARY STREAM		
DIZZINESS			ABNORMAL THIRST		
HEADACHES: ☐ FREQUENT ☐ SEVERE			PROSTATE TROUBLE		
ENLARGED GLANDS			☐ STOMACH TROUBLE ☐ ULCER		
THYROID: ☐ OVERACTIVE ☐ UNDERACTIVE ☐ ENLARGED			INDIGESTION		
ENLARGED GOITER			☐ GAS ☐ BELCHING		
SKIN DISEASE			APPENDICITIS		
COUGH: ☐ FREQUENT ☐ CHRONIC			☐ LIVER DISEASE ☐ GALL BLADDER DISEASE		
☐ CHEST PAIN ☐ ANGINA PECTORIS			☐ COLITIS ☐ OTHER BOWEL DISEASE		
SPITTING UP BLOOD			☐ HEMORRHOIDS ☐ RECTAL BLEEDING		
NIGHT SWEATS			BLACK TARRY STOOLS		
SHORTNESS OF BREATH ☐ EXERTION ☐ AT NIGHT			☐ CONSTIPATION ☐ DIARRHEA		
☐ PALPITATION ☐ FLUTTERING HEART			☐ PARASITES ☐ WORMS		
SWELLING OF ☐ HANDS ☐ FEET ☐ ANKLES			☐ ANY CHANGE IN APPETITE ☐ EATING HABITS		
VARICOSE VEINS			☐ ANY CHANGE IN BOWEL ACTION ☐ STOOLS		
EXTREME ☐ TIREDNESS ☐ WEAKNESS			EXPLAIN		

IMMUNIZATION - EKG

HAVE YOU HAD . . .	NO	YES	HAVE YOU HAD . . .	NO	YES
SMALLPOX VACCINATION (WITHIN LAST 7 YEARS)			POLIO SHOTS (WITHIN LAST 2 YEARS)		
TETANUS SHOT (NOT ANTITOXIN)			AN ELECTROCARDIOGRAM WHEN		

HABITS

DO YOU . .	NO	YES	DO YOU USE . . .	NEVER	OCC.	FREQ.	DAILY
EXERCISE ADEQUATELY			LAXATIVES				
HOW?			VITAMINS				
AWAKEN RESTED			SEDATIVES				
SLEEP WELL			TRANQUILIZERS				
AVERAGE 8 HOURS SLEEP (PER NIGHT)			SLEEPING PILLS, ETC.				
HAVE REGULAR BOWEL MOVEMENTS			ASPIRINS, ETC.				
SEX - ENTIRELY SATISFACTORY			CORTISONE				
LIKE YOUR WORK (HOURS PER DAY) ☐ INDOORS ☐ OUTDOORS			ALCOHOLIC BEVERAGES				
WATCH TELEVISION (HOURS PER DAY)			COFFEE (CUPS PER DAY)				
READ (HOURS PER DAY)			TOBACCO: ☐ CIGARETTES (PKS PER DAY)				
HAVE A VACATION (WEEKS PER YEAR)			☐ CIGARS ☐ PIPE ☐ CHEWING TOBACCO				
HAVE YOU EVER BEEN TREATED FOR ALCOHOLISM			☐ SNUFF				
HAVE YOU EVER BEEN TREATED FOR DRUG ABUSE			APPETITE DEPRESSANTS				
RECREATION: DO YOU PARTICIPATE IN SPORTS OR HAVE HOBBIES WHICH GIVE YOU RELAXATION AT LEAST 3 HOURS A WEEK.			THYROID MEDICATION: ☐ NO ☐ YES, IN PAST ☐ NONE NOW NOW ON GR. DAILY				
			HAVE YOU EVER TAKEN . . .				
			☐ INSULIN ☐ TABLETS FOR DIABETES ☐ HORMONE SHOTS ☐ TABLETS ☐ NO				

WOMEN ONLY

MENSTRUAL HISTORY . . .				NO	YES
AGE AT ONSET			ARE YOU REGULAR: ☐ HEAVY ☐ MEDIUM ☐ LIGHT		
USUAL DURATION OF PERIOD	DAYS		DO YOU HAVE ☐ TENSION ☐ DEPRESSION BEFORE PERIOD		
CYCLE (START TO START)	DAYS		DO YOU HAVE ☐ CRAMPS ☐ PAIN WITH PERIOD		
DATE OF LAST PERIOD			DO YOU HAVE HOT FLASHES		
PREGNANCIES . . .	**NO**	**YES**		**NO**	**YES**
CHILDREN BORN ALIVE (HOW MANY)			STILL BORN (HOW MANY)		
CESAREAN SECTIONS (HOW MANY)			MISCARRIAGES (HOW MANY)		
PREMATURES (HOW MANY)			ANY COMPLICATIONS		

EMOTIONS

ARE YOU OFTEN . . .	NO	YES	ARE YOU OFTEN . . .	NO	YES
DEPRESSED			JUMPY		
ANXIOUS			JITTERY		
IRRITABLE			IS CONCENTRATION DIFFICULT?		