ADULT HEALTH HISTORY AND LIFESTYLE QUESTIONNAIRE

Today's Date ______________

Name ________________________________ Date of Birth _____/_____/_______ Age _______

Details about your health history are of crucial importance as we work together to determine the best and most appropriate treatment options for you. All information provided here is confidential and cannot be shared without your written permission.

PRIMARY CARE

Primary Care Physician (PCP) ________________________ Date of last full physical exam _____/_______ (month/year)

How often do you get physical exams? ______________ How often do you get dental exams? ____________

Date of last PCP visit _____/_____ (month/year) Reason for last visit ________________________________

Medication allergies 1 ________________ 2 ________________ 3 ________________

Medications causing other bad reactions 1 ______________ 2 ______________ 3 ______________

Environmental allergies 1 ________________ 2 ________________ 3 ________________

Have you ever used a nasal steroid inhaler for allergies? ☐ No ☐ Yes

Food allergies and/or sensitivities____

Bowel Habits: Approximately how often? __________________________

Check all that apply and explain in space below: ☐ Constipation ☐ Diarrhea ☐ Accidents

Urination: Approximately how many times per day? _____

Check all that apply and explain in space below: ☐ Difficulty starting urine stream ☐ Day accidents ☐ Night accidents

Explain____

Have you had a colonoscopy or sigmoidoscopy? ☐ No ☐ Yes

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

MEDICATIONS

List **all** prescription medications and over-the-counter supplements or vitamins you take (including strength/dosage and frequency).

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

NAME________________________________ DOB:______________

YOUR FEELINGS ABOUT TAKING MEDICATION

Check all that apply.

☐ I am taking medication now
☐ I need medication
☐ I will not take medication
☐ I will take medication but only after first trying all other options
☐ I am comfortable taking medication when I trust my physician
☐ I have concerns about using medication
☐ Taking medication really hurt someone I know or made that person act unlike himself/herself
☐ I am very concerned about the cost of any medication I take because I'm on a limited budget
☐ I have difficulty swallowing pills
(Describe)____

LIFESTYLE

NUTRITION

Indicate the nutritional quality of your current eating habits (circle only one)

1	2	3	4	5
(Poor nutritional quality)		(Average)		(Well balanced, nutritious)

Describe your typical:
Breakfast ____
Lunch ____
Dinner ____
Snacks ____

Number of meals you eat most days ______ Decsribe any recent appetite change______________________
____

SUBSTANCES

Caffeine Current use ☐ No ☐ Yes How much & how often? ____________________
How does it affect you? ____________________

Nicotine ☐ Never used ☐ Past use Last use was ____________________
☐ Current use How much & how often? ____________________
(check all that apply) ___cigarettes ___chewing tobacco ___nicotine patch Ever try to quit? ☐ No ☐ Yes

Alcohol Past use ☐ No ☐ Yes When and where last used? ____________________
How much & how often? ____________________
How many drinks does it take to get you "tipsy" or "buzzed"? ____________________

Drugs Past use ☐ No ☐ Yes When, what, where last used? ____________________
What, how much, & how often? ____________________
What effects do they have on you (good and bad)? ____________________

SLEEP

Average # hours per night __________ How many hours needed to feel rested in a.m.? __________

Difficulty with (check all that apply)
☐ Falling asleep ☐ Frequent waking ☐ Early waking ☐ Others say you stop breathing while asleep
☐ Snoring ☐ Getting up ☐ Not feeling rested when finish sleeping
☐ Other ____

The longest number of hours/days you've gone without sleep but didn't feel tired ____________________

What were you doing? ____