

P L PHYSICIANS, INC.

FAMILY PRACTICE ADULT HEALTH QUESTIONNAIRE

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

PATIENT NAME: _____

PATIENT DATE OF BIRTH _____ **TODAY'S DATE** _____

What would you like to talk to your doctor about today? _____

What is the best way to reach you? cell phone
 home phone
 work phone

**May we leave a message on your machine/
voice mail?** yes
 no

Please list any medication allergies or reactions:

Please check to indicate if you have ever had the following conditions:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Abnormal heart rhythm | |
| <input type="checkbox"/> Sexually transmitted disease/type: _____ | | | |
| <input type="checkbox"/> Eye problem/type _____ | | <input type="checkbox"/> Cancer/type _____ | |
| <input type="checkbox"/> Other, please explain: _____ | | | |

When was your last physical? _____

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery/reason for hospitalization/location

Date

_____	_____
_____	_____
_____	_____

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

Please list ALL medications, including vitamins, herbal or natural supplements and prescription medications you are currently taking. Please note the dosage if possible:

Medication name

Dosage

_____	_____
_____	_____
_____	_____
_____	_____

What pharmacy do you use for prescription medications?

Are you currently receiving care from any other doctors, chiropractors, or other health care professionals? If yes we would like to know whom so that we can coordinate your care:

Provider's name

Condition for which they are treating you

_____	_____
_____	_____
_____	_____

Please note approximate dates of your most recent immunizations:

- | | | | |
|--------------------------------------|------------|--------------------------------------|------------|
| <input type="checkbox"/> Tetanus | Date _____ | <input type="checkbox"/> Influenza | Date _____ |
| <input type="checkbox"/> Pneumonia | Date _____ | <input type="checkbox"/> Hepatitis B | Date _____ |
| <input type="checkbox"/> Other _____ | Date _____ | <input type="checkbox"/> Other _____ | Date _____ |

If you have had any of the following tests done, please note when the tests were done and what the results were, if known:

Do you smoke or use any tobacco products?. Yes No Quit
Number of cigarettes each day? _____ How many Years _____

Do you drink alcohol? Yes No Quit
How much? _____ How often? _____

Have you ever felt you should cut down on your drinking? Yes No

Have you ever used illegal drugs? Yes No
If yes, are you still using them? Yes No What type? _____

Do you use seatbelts regularly? Yes No

Do you have a gun in your home? Yes No
If yes, is it kept locked unloaded Out of reach?

Do you use sunscreen regularly? Yes No

Personal History

Do you have transportation to and from Doctor's office? Yes No

Are you currently married or have a significant other? Yes No

Who lives with you at home? _____

Are you employed? Yes No

If yes, what kind of work do you do? _____

If no, is this by choice? _____ Disability? _____ Other reasons? _____

Do you feel there is something seriously wrong with your body? Yes No

Do you often feel sad or depressed? Yes No

Do you have money problems that limit you access to food, shelter or medical care? Yes No

In the last year have there been any major changes in your life like marriage, divorce, death of a family member or close friend, illness or injury, or change in job situation? Yes No

Do you have some form of church or spiritual support? Yes No

Do you have an advanced directive or living will? Yes No

Sexual History

Are you currently sexually active? Yes No

If no, have you been in the past? Yes No

If yes, how many partners? _____ Whom with? Men Women Both

Do you feel you are at risk for HIV/AIDS? Yes No

