

# Established Patient (Adult) Questionnaire Update

In order to get to keep your health records current, please answer the following questions:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Country of Birth \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

What is the nature of the problem that brought you to the office today?

## General Health History

Please circle the appropriate answer or provide information where necessary.

Sex: Male Female Race: \_\_\_\_\_

Height: \_\_\_\_\_ ft . \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

Please rate your current health status: poor / average / good / excellent

Please rate your current energy level: poor / average / good / excellent

Do you currently smoke? Yes / No How long? (years) \_\_\_\_\_ How many packs per day? \_\_\_\_\_

Have you smoked in the past? Yes / No When did you stop? \_\_\_\_\_ How many packs per day? \_\_\_\_\_

Do you consume alcoholic beverages? ( Beer / Wine / Liquor ) Yes / No

How often? Daily 2-3 week On weekends On rare occasions

Do you exercise regularly? Yes / No

How often? Daily 2-3 x a week Rarely

Have you GAINED weight over the last 5 years? Yes / No If "Yes", how many lbs? \_\_\_\_\_

Have you LOST weight over the last 5 years? Yes / No If "Yes", how many lbs? \_\_\_\_\_

Do you have, or have you had any of the following health problems? (N=no, Y=yes, P=past, C=Current)  
(Provide additional information below)

- |   |            |  |
|---|------------|--|
| N | Y: ( P C ) | Cardiac (heart)  |
| N | Y: ( P C ) | Blood Pressure   |
| N | Y: ( P C ) | Stroke   |
| N | Y: ( P C ) | Cancer -- Type _____                                     |
| N | Y: ( P C ) | Pulmonary / Respiratory                                  |
| N | Y: ( P C ) | Diabetes / Hypoglycemia                                  |
| N | Y: ( P C ) | Gastro -Intestinal Problems                              |
| N | Y: ( P C ) | Bleeding / Blood Clotting Problem                        |
| N | Y: ( P C ) | Neurologic   |
| N | Y: ( P C ) | Psychiatric  |
| N | Y: ( P C ) | Thyroid  |
| N | Y: ( P C ) | Allergies / Hay Fever / <b>Latex Gloves / Anesthesia</b> |
| N | Y: ( P C ) | Endocrine / Hormonal                                     |
| N | Y: ( P C ) | Nasal Obstruction / Chronic Sinusitis                    |
| N | Y: ( P C ) | Throat / Voice / Hoarseness                              |
| N | Y: ( P C ) | Language / Articulation / Resonance                      |
| N | Y: ( P C ) | Hearing Loss / Balance or dizziness                      |
| N | Y: ( P C ) | Other: _____   |

Are you allergic to any medications? Yes / No

If "Yes", please provide name of medication (s) \_\_\_\_\_

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Are you currently taking any medication, prescription and/or non-prescription? Yes / No

If "Yes" provide the information below

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Do you use any blood "thinners" such as Coumadin or aspirin? Yes / No (List)

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Do you use any herbal or "alternative" medications or supplements? Yes / No (List)

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Do you use any type of "diet" pills? Yes / No (List) \_\_\_\_\_

Have you had any surgeries? Yes / No If "Yes", provide the details below:

Surgery: \_\_\_\_\_ Year of Surgery: \_\_\_\_\_

Surgery: \_\_\_\_\_ Year of Surgery: \_\_\_\_\_

Surgery: \_\_\_\_\_ Year of Surgery: \_\_\_\_\_

Surgery: \_\_\_\_\_ Year of Surgery: \_\_\_\_\_

Surgery: \_\_\_\_\_ Year of Surgery: \_\_\_\_\_

Surgery: \_\_\_\_\_ Year of Surgery: \_\_\_\_\_

**Thank you for your assistance!**

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**For office use only:**

Reviewed: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_ M.D.

Date: \_\_\_\_\_