RICHMOND
Family Medicine
30 West Main Street
Richmond, VT 05477

ADULT HEALTH HISTORY QUESTIONNAIRE *and* SUMMARY OF CURRENT HEALTH STATUS

NAME: **DOB:**

In completing this form, please be as detailed as possible. The information you provide will give us a comprehensive history of your medical concerns, allowing us to deliver the best care for your specific needs.

REVIEW OF SYMPTOMS: Please check the box for any **persistent** symptoms you have had in the **past few months**.

❑ Unexplained weight loss/gain	❑ Shortness of breath	❑ Easy bruising
❑ Unexplained fatigue/weakness	❑ Heartburn/reflux/indigestion	❑ Headache
❑ Fall asleep during day when sitting	❑ Blood/changes in bowel movement	❑ Memory loss
❑ Skin: New mole/change in mole	❑ Constipation	❑ Fainting
❑ Skin: Rash/itching	❑ Leaking urine	❑ Dizziness
❑ Breast lump/pain/nipple disch.	❑ Blood in urine	❑ Numbness/tingling
❑ Nosebleeds, trouble swallowing	❑ Increased frequency of urination	❑ Unsteady gait
❑ Frequent sore throat, hoarseness	❑ Penile/Vaginal discharge	❑ Frequent falls
❑ Hearing loss/ringing in ears	❑ Concern with sexual function	❑ Hay fever/allergies
❑ Change in vision/eye pain/redness	❑ Neck pain	❑ Frequent infections
❑ Chest pain/discomfort	❑ Back pain	❑ Anxiety/stress/irritability
❑ Fast/irregular heartbeat	❑ Muscle/joint pain_______________	❑ Sleep problem
❑ Cough/wheeze	❑ Heat or cold sensitivity	❑ Lack of concentration
❑ Loud snoring	❑ Swollen glands	❑ Problem with menstrual periods

SOCIAL HISTORY:

Occupation: ____ Employment Status: ________________________________
Employer: ____ Years of education/highest degree: _________________
Marital Status: ______________________________________ Spouse/Partner's Name:___________________________
Number of children: ______________ Ages of children:____________________ Number of grandchildren:______________
Who lives at home with you?____
Leisure activities, group involvement, religion, volunteer work, recent travel:______________________________________
____

WOMEN'S HEALTH HISTORY:

Total # of pregnancies: ___________ Number of births: ___________
Date (month/day if known) of last menstrual period if you are still menstruating:________________________________
Age at beginning of periods (menstruation):________________ Age at end of periods (menopause):_______________

OTHER HEALTH ISSUES:

Tobacco Use ❑Never ❑No ❑Yes
Former smoker:
Quit date: __________ Smoked for _________ Years
Smoked _____________ packs per day.
Current smoker:
I have smoked for ______________ years
I smoke ______________ packs per day
Other tobacco: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew
❑ Vaping ❑ Other:_____________

Alcohol Use ❑Never ❑No ❑Yes
I drink _____(#) drinks/wk ❑Beer ❑Wine ❑Liquor

Drug Use
Do you use marijuana or recreational drugs? ❑No ❑Yes
Have you ever used needles to inject drugs? ❑No ❑Yes

Exercise/Diet: Do you exercise regularly? ❑No ❑Yes
What kind of exercise?_____________________________
How long and how often?___________________________
How would you rate your diet? ❑Good ❑Fair ❑Poor

Safety: Do you use a bike helmet? ❑ N/A ❑ No ❑ Yes
Do you use seatbelts consistently? ❑ No ❑ Yes
Working CO/Smoke detector in home? ❑ No ❑ Yes
Do you wear sunscreen regularly? ❑ No ❑ Yes
Are guns locked in home? ❑ N/A ❑ No ❑ Yes
Any concerns about your safety? ❑ No ❑ Yes
Do you have an Advance Directive? ❑ No ❑ Yes

Sexual Activity: Are you sexually involved? ❑ No ❑ Yes
Your gender identity? ❑M ❑F ❑Other______________
Sexual partners have been: ❑M ❑F ❑Other__________
Birth Control Method(s):____________________________