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

IMMUNIZATIONS: Check off any vaccinations you have had. Add the year, if known.

Tetanus (Td) ❑ With Pertussis (Tdap) ❑ Varicella (Chicken Pox) shot *or* illness ❑ Pneumovax (pneumonia) ❑
Influenza (flu shot) ❑ Hepatitis A ❑ Hepatitis B ❑ MMR ❑ Meningitis ❑ Zostavax (shingles) ❑ HPV ❑

MEDICATIONS: List **ALL** medications you are currently taking. Include prescribed, OTC, vitamins, home remedies, birth control pills, supplements, inhalers, etc. Attach additional pages if more room is needed.

Medication	Dose/Frequency	Medication	Dose/Frequency

ALLERGIES: List any allergies you have, including food, drug, or other sources. Include details on the type of reaction.

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (Cholesterol)	Date:_____	Abnormal?	❑ No ❑ Yes
Colonoscopy	Date:_____	Polyp(s)?	❑ No ❑ Yes
Mammogram	Date:_____	Abnormal?	❑ No ❑ Yes
Pap Smear	Date:_____	Abnormal?	❑ No ❑ Yes
Bone Density Test	Date:_____	Abnormal?	❑ No ❑ Yes

PERSONAL MEDICAL HISTORY: Do you have (current) or have you had (past) any of the following conditions?

Condition	***Current***	***Past***	***Comments***
Alcohol/Drug Abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder/Kidney Problems			
Blood Clots			
Blood Transfusion			
Breast Lump (benign)			
Cancer: Breast			
Cancer: Colon			
Cancer: Other Type			
Cancer: Ovarian			
Cancer: Prostate			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes			
Diverticulosis			
Emphysema			
Fractures (broken bones)			
Gallblader Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Gout			
Gynecological Conditions			
Heart Attack			
Hepatitis (Specify Type)			
High Blood Pressure			
High Cholesterol			
Irritable Bowel Syndrome			
Kidney Disease			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate Conditions			
Seizures/Epilepsy			
Skin Conditions (Specify Type)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid Disease			
Other:			
Other:			
Other:			

SURGICAL HISTORY: Please check off any procedure or surgeries. List any abnormal finding or complications.

Procedure	***Year***	***Comments***
Abdominal Surgery		
Appendectomy		
Back Surgery		
Biopsy		
Breast Biopsy		
Breast Surgery		
Colonoscopy		
Coronary Bypass		
Coronary Stent		
EGD (Stomach Endoscopy)		
Cataract		
Gallbladder Removal		
Heart Surgery (other than coronary bypass)		
Hip Surgery		
Hysterectomy		
Knee Surgery		
LEEP (Cervix Surgery)		
Neck Surgery		
Ovary Ligation		
Ovary Removal		
Vasectomy		
Sigmoidoscopy		
Sinus Surgery		
Other (list)		

FAMILY HISTORY: Indicate which relative has had the following diseases. If relative is deceased, indicate cause and year in the comments section. IF YOU ARE ADOPTED AND DO NOT KNOW YOUR FAMILY HISTORY, CHECK HERE: ❑

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	***Comments***
No significant history known									
Alcoholism/Drug Abuse									
Alzheimers									
Asthma									
Autoimmune Disease									
Bleeding or clotting disorder									
Cancer: Breast									
Cancer: Colon									
Cancer: Other Type									
Cancer: Ovarian									
Cancer: Prostate									
Colon Polyp									
Coronary Artery Disease									
Depression/Suicide/Anxiety									
Diabetes									
Emphysema/COPD									
Genetic Disorder (Please Explain)									
Glaucoma									
Heart Disease									

FAMILY HISTORY: *(Continued)*

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	***Comments***
Hepatitis B or C									
High Blood Pressure/Hypertension									
High Cholesterol									
Hip Fracture									
Hypothyroidism/Thyroid Disease									
Kidney Disease									
Kidney Stones									
Macular Degeneration									
Migraine Headaches									
Osteoporosis									
Other:									
Other:									

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):_____