ARIZONA COMMUNITY PHYSICIANS

Adult Health Questionnaire

Name: _____

Birthdate: _____

Phone: (H) _____ (W) _____

(C) _____

Personal Health History

General Information

How long have you lived in Arizona? _____ ❍ Yes ❍ No Did you move here for health reasons?

Where did you live before Arizona? _____ How long? _____

What is your occupation? _____ How long? _____

What is your blood pressure? Systolic (top number) _____ Diastolic (bottom number) _____

If you do not know your blood pressure, check (✓) the box that describes your blood pressure: ❍ High ❍ Low or Normal ❍ Low

What is your cholesterol level? ❍ High ❍ Normal ❍ Unknown What was your HDL cholesterol level? ❍ High ❍ Normal ❍ Low

What was your most recent blood cholesterol? _____ mg/dl What was your most recent blood HDL? _____ mg/dl

Allergies

Do you have any Allergies? If so, please list:

Allergic To	Reaction	Date

Advance Directives

❍ Yes ❍ No

Social History

HABITS:

TOBACCO USE: Circle one of the following: Never Yes but quit Yes currently smoke

If stopped smoking how many years did you smoke? _____

If currently smoke, how many cigarettes a day? _____ What age did you start smoking? _____

ALCOHOL USE: ❍ YES ❍ NO If yes, circle the one that applies:

Less than one drink a week, Two or more drinks a week, Three or more drinks a DAY, Other _____

Circle the following that apply: Beer Wine Hard liquor

RECREATIONAL DRUGS: ❍ NO or ❍ YES Circle ones that apply: marijuana, cocaine, meth, other _____

Medications

Are you currently taking any medication (including inhalers)? If yes, please check (✓) any that apply.

Medication (for)	Name/Type of Medication	Dose	Medication (for)	Name/Type of Medication	Dose
❍ Allergy			❍ Heart		
❍ Arthritis/Joint Pain			❍ Laxatives (Constipation)		
❍ Aspirin			❍ Anxiety/Panic Disorder		
❍ Birth Control Pills			❍ Pain		
❍ Blood Pressure/Thyroid			❍ Recreational Drugs (optional)		
❍ Blood Thinners			❍ Ulcers/Stomach/Intestinal		
❍ Breathing			❍ Water Pills (diuretics)		
❍ Cholesterol Lowering			❍ Supplemental Oxygen		
❍ Cortisone (Steroids)					

Please list all other medications: _____

Immunizations/Vaccinations

Check (✓) those you have had and write in dates below:

❍ Regular measles	Date:	❍ Hepatitis A	Date:	❍ Flu (most recent)	Date:
❍ Mumps	Date:	❍ Hepatitis B	Date:	❍ Pneumonia Vaccine	Date:
❍ German measles	Date:	❍ Tetanus (most recent)	Date:	❍ Other	Date:
❍ Diptheria	Date:	❍ Polio	Date:	❍ Other	Date:

Past History

Do you have or have you been told that you have had any of the following conditions? (please check (✓) any that apply)

❍ Alcohol Problems	❍ Cancer (type below)	❍ Epilepsy	❍ Liver Trouble
❍ Allergies	❍ Chronic Back Pain	❍ Glaucoma	❍ Mental Illness
❍ Anxiety/Panic Disorder	❍ Colon Polyps	❍ HIV/AIDS	❍ Sexual Problems
❍ Arthritis/Rheumatism	❍ Congestive Heart Failure	❍ Heart Attack/Angina	❍ Stroke
❍ Asthma	❍ Deafness	❍ High Cholesterol	❍ Sugar Diabetes
❍ Blindness	❍ Drug Abuse	❍ Hypertension/High Blood Pressure	❍ Ulcer/Intestinal Bleeding
❍ Alcoholism	❍ Emphysema	❍ Kidney Stones or Disease	❍ Valley Fever

❍ Other _____

Hospitilizations/Surgeries

Please list hospitalizations and surgeries within the last 10 years - include facility:

Name of Facility	City	State	Diagnosis	Date

❍ Yes ❍ No Have you ever been advised to have a surgical operation which you have not undergone? If yes, please explain:

Family History

Has any member of your immediate family (father, mother, sister, brother, grandparents) had problems in the following areas?

❍ Alcohol Problems	❍ Cancer of Colon	❍ Deafness	❍ High Cholesterol
❍ Arthritis/Rheumatism	❍ Cancer of Ovary	❍ Drug Abuse	❍ Kidney Stones
❍ Asthma	❍ Cancer of Prostate	❍ Glaucoma	❍ Mental Illness/Depression/Suicide
❍ Blindness	❍ Child Abuse	❍ Heart Disease	❍ Stroke
❍ Cancer of Breast	❍ Colon Polyps	❍ High Blood Pressure	❍ Sugar Diabetes

❍ Other _____

FAMILY HISTORY	AGE	STATE OF HEALTH OR CAUSE OF DEATH	CHECK IF DECEASED	FAMILY HISTORY	AGE	STATE OF HEALTH OR CAUSE OF DEATH	CHECK IF DECEASED
Father				Husband/Wife			
Mother				Children			
Brothers & Sisters				1.			
1.				2.			
2.				3.			
3.				4.			
4.				5.			