

FCHS ADULT HEALTH QUESTIONNAIRE

Patient Name: _____ Date: _____ Chart: _____

Birthdate: _____ Sex: _____ Occupation: _____
Month Day Year M F

Please list all medications you now use including prescription and non-prescription drugs, aspirin, vitamins, herbal medications, and birth control pills:

Name of drug: _____ Dose: _____ How often? _____

Please list any allergies, especially to drugs:

Please list all hospitalizations, surgery, and serious illness or injury:

Year: _____ Problem: _____

Please list approximate year of any immunizations (shots):

Last tetanus: _____ Hepatitis B: _____ Pneumococcal (pneumovax): _____
MMR / Rubella: _____ Hepatitis A: _____ Other: _____

Please check any of the following which you have had:

- | | | |
|---|--|--|
| <input type="checkbox"/> Abnormal pap smear | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis / jaundice |
| <input type="checkbox"/> Abnormal mammogram | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy, Seizures | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Malaria / Parasites |
| <input type="checkbox"/> Bladder or kidney disorder | <input type="checkbox"/> Emotional / nervous disorder | <input type="checkbox"/> Phlebitis (blood clots) |
| <input type="checkbox"/> Bronchitis (frequent) | <input type="checkbox"/> Emphysema / chornic lung disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Colitis / colon polyps | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Hayfever / allergies / sinus problems | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Cholesterol problems | <input type="checkbox"/> Headaches (frequent/severe/migrane) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chicken Pox / shingles | <input type="checkbox"/> Heart Disease / Stroke | <input type="checkbox"/> Ulcers |

Do you use: _____ Cigarettes? _____ Other Tobacco? _____ Seat Belts?

Please check any of the following which your family (grandparents, parents, brothers or sisters, children, others) have:

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia / bleeding disorder | <input type="checkbox"/> Colon polyps | <input type="checkbox"/> Headaches (frequent/severe/migraine) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease / stroke |
| <input type="checkbox"/> Asthma, allergies, eczema | <input type="checkbox"/> Depression | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Emotional / nervous disorder | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cholesterol problems | <input type="checkbox"/> Glaucoma | |