IU Health Physicians

# Adult Patient History Questionnaire

PATIENT LABEL

**NAME:** *(Last, First, Middle Initial)* | Today's Date

Last four digits SSN# | Date of Birth | Age

Referring Physician: | Family Physician:

## *YOUR MEDICAL HISTORY*

| | | |
|---|---|---|
| Hypertension/High Blood Pressure ☐ | Blood Clots/Abnormal Clotting ☐ | Cancer ☐ |
| Heart Disease/Coronary Artery Disease ☐ | Abnormal Bleeding ☐ | Kidney Disease ☐ |
| Irregular Heart Rhythm ☐ | Diabetes ☐ | HIV/AIDS ☐ |
| High Cholesterol ☐ | Rheumatoid Arthritis ☐ | Hepatitis A B C ☐ |
| Peripheral Vascular Disease ☐ | Gout ☐ | Obesity ☐ |
| Reflux Disease/Heartburn ☐ | Sleep Apnea ☐ | List any other conditions here: |
| Stomach Ulcers ☐ | Osteoporosis ☐ | |
| Asthma ☐ | Thyroid Disease ☐ | |
| COPD/Emphysema ☐ | Stroke ☐ | |

## *PAST MEDICAL SURGICAL HISTORY*

| PLEASE LIST ALL OF THE PATIENT'S OPERATIONS/SURGERIES | DATE | PLEASE LIST ALL OF THE PATIENT'S CONDITIONS |
|---|---|---|
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***PLEASE GIVE DATES AND REASONS FOR ANY HOSPITALIZATION WHICH THE PATIENT WAS NOT IN FOR SURGERY***

| APPROXIMATE DATE/REASON | | APPROXIMATE DATE/REASON | |
|---|---|---|---|
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## *SOCIAL HISTORY*

Marital Status : ☐ Married ☐ Single ☐ Widow(er) ☐ Divorced

Are you currently working? ☐ Employed ☐ Part-Time ☐ Retired ☐ Student ☐ Unemployed

Occupation _____

Do you drink alcohol? ☐ 1-2 times per year ☐ 1-2 times per month ☐ 1-2 time per week ☐ 3-5 times per week ☐ Daily ☐ No

Do you smoke? ☐ Yes, current ☐ Yes, past ☐ No

If yes, how much? _____ packs per day for _____ years

Quit ☐ (Year you quit: _____) _____ packs per day for _____ years

History of substance abuse? ☐ Yes, current ☐ Yes, past ☐ No

If yes, what substance: _____

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## *FAMILY MEDICAL HISTORY*

**FATHER** ☐ ALIVE (Age _____ ) ☐ DECEASED (Age _____ ) ☐ UNKNOWN *Cause of Death* _____
**MOTHER** ☐ ALIVE (Age _____ ) ☐ DECEASED (Age _____ ) ☐ UNKNOWN *Cause of Death* _____

**Please indicate whether any of the patient's BLOOD RELATIVES have had any of the medical illnesses listed below:**

| | MOTHER | FATHER | GRANDMOTHER | GRANDFATHER | SISTER | BROTHER | DAUGHTER | SON |
|---|---|---|---|---|---|---|---|---|
| **IF HISTORY UNKNOWN, PLEASE CHECK HERE** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Coronary Artery Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Valve Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Irregular Heart Rhythm | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Peripheral Vascular Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes Type 1 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes Type 2 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Obesity | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Blood Clots | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hepatitis A B C | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Immunodeficiency | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke/TIA | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lung Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Additional Information about your family that you want us to know _____

## *MEDICATIONS*

**Please list all of the patient's current PRESCRIPTION MEDICATIONS: (If the patient has prepared a prescription medication list already, please bring it in and we will complete this section. Also, it will be helpful if the patient brings all of the patient's medications in bottles.)**

**PREFERRED PHARMACY:**
**Pharmacy Name:** _____ **Pharmacy Address:** _____

| MEDICATION | DOSAGE | NUMBER OF TIMES/DAY | REASON FOR WHICH YOU TAKE THIS |
|---|---|---|---|
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## *ALLERGIES*

**Please list all of the patient's ALLERGIES:**

| ALLERGY: | REACTION: |
|---|---|
| | |
| | |
| | |

Patient Intake History Records