BAYLOR FAMILY MEDICINE SOUTHWEST
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ADULT HISTORY QUESTIONNAIRE

NAME: ______________________________**DATE:** ____________**DOB**: ____________**CHART#:** ____________

PAST MEDICAL HISTORY: Please check any of the following medical conditions you have had in the past. **Please note date of onset:** (Ex. _X_ Migraine Headache – 1979)

☐ Abnormal Heart Rhythm
☐ Allergic Rhinitis
☐ Anemia/Blood Disorder
☐ Angina/Chest Pain
☐ Anxiety
☐ Asthma
☐ Cancer, Type: ______________________
☐ Colitis
☐ Depression
☐ Diabetes
☐ Elevated Cholesterol
☐ Emphysema / COPD
☐ Gastro-Esophageal Reflux Disease
☐ Genital Warts
☐ Glaucoma
☐ Heart Attack
☐ Heart Failure
☐ Heart Murmur
☐ Hepatitis / Liver Problems
☐ Herpes
☐ HIV / AIDS
☐ High Blood Pressure
☐ Kidney Problems
☐ Migraine Headache
☐ Obstructive Sleep Apnea
☐ Peptic Ulcer Disease
☐ Pneumonia
☐ Rheumatic Fever
☐ Seizures
☐ Stroke / TIA
☐ Substance Abuse
☐ Thyroid Problem
☐ Tuberculosis

OTHER MEDICAL HISTORY: List any other medical condition you have been diagnosed with and the date of onset:

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SURGICAL HISTORY: List all surgeries and include the date of the surgery:

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____

MEDICATIONS: (List **ALL** medications, prescribed and over the counter, herbs and supplements):

	DRUG	STRENGTH	HOW OFTEN	LENGTH OF TIME TAKEN
Ex:	Advil	200mg	3 times a day	6 months

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ALLERGIES TO MEDICATIONS: (List all allergies to **medications ONLY** and the type of reaction to each)

____

____

TOBACCO USE:

Do you currently use any type of tobacco products? ☐ Yes Type and quantity per day: ______________________________
☐ No Date of cessation: ______________________________________

ALCOHOL/CAFFEINE USE:

How many drinks of alcohol do you consume per week?
___ 0 ___ < 6 ___ < 12 ___ < 24 ___ > 24

Coffee/Tea: (Cups/glasses per day) _________________ Sodas per day: _________________

MARITAL STATUS (ALL PATIENTS):

( ) Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced ( ) Other __________________________________

OB/GYN HISTORY (Female Patients)

Number of pregnancies? __________________

Number of miscarriages? __________________

Number of Living Children? ________________

Date of last menstrual cycle? _______________

Have you ever had an abnormal pap test?
☐ Yes ☐ No

Date of last pap _________________________

CHILDREN (Names and Birth Dates)

_____________________________________ ____________

_____________________________________ ____________

_____________________________________ ____________

_____________________________________ ____________

_____________________________________ ____________

FAMILY HISTORY:

Please mark in the brackets ( ) any medical conditions your family has had using the following abbreviations: Mother (**M**), Father (**F**), Brother (**B**), Sister (**S**), Grandparent (**GP**), Aunt (**A**), Uncle (**U**)
For example, if your Aunt and Mother had breast cancer: (**A, M**) Breast Cancer

( ) Anemia/Blood Disorder	( ) Diabetes	( ) Kidney Disease	( ) Substance Abuse
( ) Asthma	( ) Elevated Cholesterol	( ) Migraine	( ) Thyroid Disorder
( ) Arthritis	( ) Emphysema / COPD	( ) Osteoporosis	( ) Tuberculosis
( ) Cancer, Type ____________________	( ) Glaucoma	( ) Prostate Cancer	
( ) Colon Polyps	( ) Heart Disease	( ) Seizures	
( ) Depression / Anxiety	( ) High Blood Pressure	( ) Stroke / TIA	

LIVING	AGE OR AGE AT DEATH	PRESENT HEALTH/CAUSE OF DEATH
Father ☐ Yes ☐ No	____________________	_________________________________
Mother ☐ Yes ☐ No	____________________	_________________________________
Siblings:		
__________________	____________________	_________________________________
__________________	____________________	_________________________________
__________________	____________________	_________________________________
__________________	____________________	_________________________________
__________________	____________________	_________________________________
__________________	____________________	_________________________________

PATIENT NAME: ________________________________ **CHART #:** _____________________________