Adult History and Review of Systems Questionnaire

Note: This is a confidential record of your medical history. As your doctors, it is important for us to know this information so we can provide you with the best health care possible. The information contained here will not be released to anyone without your prior consent.

Name _____ Date _____

Date of Birth _____ ☐ Male ☐ Female Spouse\Significant Other _____

SOCIAL HISTORY:

Birthplace _____ Your Occupation _____

Nationality _____ Education _____

Religion _____ Marital Status _____How many years_____

Drug Use_____ Children_____

Tobacco Use ☐ Yes ☐ No Type _____ _____

Packs per day ____ for ____ years Quit _____ Pets _____

Alcohol Use _____ Exercise (type/how often?)_____

Drinks _____ per ☐ day ☐ week ☐ month Recent or Frequent Travel Destinations _____

_____

If heavy use, how many years _____ Quit _____

Caffeine (coffee, tea, soda, chocolate) Servings per day_____

Have YOU ever had? (IF YES, CHECK APPROPRIATE BOXES)

- ☐ Cancer Type:_____
- ☐ Heart Attack/Coronary
- ☐ Artery Disease
- ☐ Rheumatic Fever
- ☐ Heart failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Gallstones
- ☐ Liver Disease
- ☐ Hepatitis/Jaundice
- ☐ Ulcer disease
- ☐ Heartburn / Reflux
- ☐ Asthma
- ☐ Seizures
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Positive TB Skin Test
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Gout
- ☐ Frequent Bladder Infection
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ Polio
- ☐ Chicken Pox
- ☐ Infectious Mono
- ☐ Anemia
- ☐ Frequent Sinus Infections
- ☐ Glaucoma
- ☐ Thyroid Trouble
- ☐ Hives
- ☐ Depression
- ☐ Head Injury
- ☐ Broken Bones
- ☐ Blood transfusions
- ☐ Sexually Transmitted Diseases: Herpes, HIV,
- ☐ Gonorrhea, Chlamydia,
- ☐ Syphilis
- ☐ Intravenous drug abuse
- ☐ Needle injury
- ☐ Mumps
- ☐ Migraines
- ☐ Prostate Enlargement
- ☐ Cystic Fibrosis
- ☐ Malaria
- ☐ Other_____

_____

IMMUNIZATIONS:

- ☐ Measles, Mumps and Rubella Vaccine
- ☐ Chicken pox vaccine
- ☐ Hepatitis B vaccine
- ☐ Influenza vaccine
- ☐ Pneumococcal vaccine
- ☐ Tetanus booster

PAST SURGICAL HISTORY: If yes, please check the box and enter the year.

- ☐ Eyes (Laser or Vision Corrected) ____
- ☐ Eyes (Cataract/Glaucoma) ____
- ☐ Ears ____
- ☐ Sinus/Nasal Septum ____
- ☐ Tonsils/Adenoid ____
- ☐ Thyroid ____
- ☐ Heart ____
- ☐ Stomach ____
- ☐ Varicose Veins ____
- ☐ Gall Bladder _____
- ☐ Appendix _____
- ☐ Intestine/Colon _____
- ☐ Hemorrhoids _____
- ☐ Hernia _____
- ☐ Breast _____
- ☐ Uterus/Hysterectomy _____
- ☐ Ovaries _____
- ☐ Spinal Surgery/Neck _____
- ☐ Prostate _____
- ☐ Spinal Surgery/Back _____
- ☐ Orthopedic (Hips/ Knee _____
- ☐ Shoulder/ Feet/Hands) _____
- ☐ C-section _____

_____

- ☐ Vasectomy _____
- ☐ Tubal Ligation _____

☐ OTHER _____

ALLERGIES and Bad Reactions to Medications: _____ _____

_____ _____

_____ _____

MEDICATIONS: Name Dosage Times a day

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Has anyone in your FAMILY ever had? **(If yes check box and list relationship)**

☐ Cancer & Type	_____	☐ Dialysis	_____	☐ Crohn's/colitis	_____
☐ Diabetes	_____	☐ Chronic lung disease	_____	☐ Alzheimer's	_____
☐ Cardiac Dysrhymthia	_____	☐ Tuberculosis	_____	☐ Alcoholism	_____
☐ Congestive Heart Failure	_____	☐ Rheumatoid Arthritis	_____	☐ Bleeding tendency	_____
☐ Coronary Artery Disease	_____	☐ Thyroid trouble	_____	☐ Anemia	_____
☐ Valvular heart Disease	_____	☐ Osteoporosis	_____	☐ Gout	_____
☐ High Blood Pressure	_____	☐ Cystic Fibrosis	_____	☐ Depression	_____
☐ High Cholesterol	_____	☐ Asthma	_____	☐ Mental illness	_____
☐ Stroke	_____	☐ Peptic Ulcer	_____	☐ Seizures	_____
☐ Kidney stones	_____	☐ Gallstones	_____	☐ Migraine headaches	_____
☐ Kidney disease	_____				
☐ OTHER	_____				

GYNECOLOGICAL/ OBSTETRICAL HISTORY:

Name of OB-GYN _____

Age when you Started Menstruating? _____ Number of Pregnancies? _____

Date of Last PAP? _____ Number of Births? _____

History of abnormal Pap's Yes / No (Please circle) Vaginal / C-section (Please Circle)

Date of Last Mammogram? _____ Method of Contraception _____

History of Abnormal Mammograms Yes / No (Please circle)
Menstrual Cycles? Regular / Irregular (Please Circle)
Pain with Periods? Yes / No (Please Circle)
Age at Menopause? _____

Do you CURRENTLY have? (IF YES, CHECK APPROPRIATE BOXES)

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain >10 pounds
- ☐ Weight Loss >10 pounds

SKIN
- ☐ Nail Changes
- ☐ New Lesions
- ☐ Rash
- ☐ Skin Color Changes

HEENT
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Decreased Hearing
- ☐ Earache
- ☐ Ear Ringing
- ☐ Nose Bleeds
- ☐ Dry Mouth
- ☐ Hoarseness
- ☐ Oral Ulcers
- ☐ Sore Throat

NECK
- ☐ Neck Pain
- ☐ Swollen Glands

RESPIRATORY
- ☐ Chronic Cough
- ☐ Decreased Exercise Tolerance
- ☐ Difficulty Breathing
- ☐ Coughing Up Blood
- ☐ Sputum Production
- ☐ Wheezing

BREAST
- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Nipple Discharge
- ☐ Skin Changes

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Leg Pains with walking
- ☐ Leg Swelling
- ☐ Night Awakening due to trouble Breathing
- ☐ Palpitations
- ☐ Shortness of Breath

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal Bleeding
- ☐ Trouble Swallowing

GENITOURINARY
- ☐ Vaginal Discharge
- ☐ Menstrual Irregularities
- ☐ Difficulty Starting/Stopping urinary Stream
- ☐ Painful Urination
- ☐ Change in Urinary Stream
- ☐ Increased Frequency
- ☐ Blood in Urine
- ☐ Loss of Bladder Control
- ☐ Nighttime Urination
- ☐ Urinary Retention
- ☐ Urethral Discharge
- ☐ Impotence
- ☐ Penile Lesions
- ☐ Testicular Mass
- ☐ Testicular Pain

MUSCULOSKELETAL
- ☐ Decreased Range of Motion
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Muscle Wasting
- ☐ Muscle Weakness
- ☐ Muscle Aches/Pains

NEUROLOGICAL
- ☐ Loss of Bowel Control
- ☐ Dizziness/Vertigo
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Passing Out
- ☐ Seizures
- ☐ Tremor

PSYCHIATRIC
- ☐ Anxiety
- ☐ Change in Sleep Pattern
- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal Thoughts

ENDOCRINE
- ☐ Appetite Changes
- ☐ Cold Intolerance
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ Hair Changes
- ☐ Sexual Dysfunction

HEMATOLOGY
- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Prolonged Bleeding

Name:_____ Date:_____

Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF)

Taking everything into consideration, during the past week how satisfied have you been with your.....

	Very Poor	Poor	Fair	Good	Very Good
.....physical health?	1	2	3	4	5
.....mood?	1	2	3	4	5
.....work?	1	2	3	4	5
.....household activities?	1	2	3	4	5
.....social relationships?	1	2	3	4	5
.....family relationships?	1	2	3	4	5
.....leisure time activities?	1	2	3	4	5
.....ability to function in daily life?	1	2	3	4	5
.....sexual drive, interest and/or performance?*	1	2	3	4	5
.....economic status?	1	2	3	4	5
.....living/housing situation?*	1	2	3	4	5
.....ability to get around physically without feeling dizzy or unsteady or falling?*	1	2	3	4	5
.....your vision in terms of ability to do work or hobbies?*	1	2	3	4	5
.....overall sense of well being?	1	2	3	4	5
.....medication? (If not taking any, check here _____ and leave item blank.)	1	2	3	4	5
.....How would you rate your overall life satisfaction and contentment during the past week?	1	2	3	4	5

*If satisfaction is very poor, poor or fair on these items, please UNDERLINE the factor(s) associated with a lack of satisfaction.