

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_

### **ADULT CHECK-UP**

This questionnaire is part of your confidential medical record. Your answers to these questions will help us provide you with the best care and help you to become and stay in good health. If you do not wish to answer any of the following questions, feel free to leave them blank. Thank you.

1) **Physical Health:** Since your last exam have you had any of the following?

- |                                             |                                                 |                                                 |                                                 |
|---------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Skin problem/rash  | <input type="checkbox"/> TB or exposure to TB   | <input type="checkbox"/> Episodes of numbness   | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Worrisome mole     | <input type="checkbox"/> High cholesterol       | <input type="checkbox"/> Stroke                 | <input type="checkbox"/> Ulcer/stomach trouble  |
| <input type="checkbox"/> Hearing trouble    | <input type="checkbox"/> Chest pain             | <input type="checkbox"/> Phlebitis/blood clots  | <input type="checkbox"/> Bloody stools          |
| <input type="checkbox"/> Ear problem        | <input type="checkbox"/> Heart rhythm problem   | <input type="checkbox"/> Thyroid problem        | <input type="checkbox"/> Hepatitis/Jaundice     |
| <input type="checkbox"/> Nose/sinus problem | <input type="checkbox"/> Heart attack           | <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Weight problem         |
| <input type="checkbox"/> Seeing/eye problem | <input type="checkbox"/> Anemia/low blood       | <input type="checkbox"/> Poor circulation       | <input type="checkbox"/> Sexual problem         |
| <input type="checkbox"/> Breast lump        | <input type="checkbox"/> Kidney/bladder trouble | <input type="checkbox"/> Arthritis/bone problem | <input type="checkbox"/> VD/Venereal disease    |
| <input type="checkbox"/> Breathing problem  | <input type="checkbox"/> Urinary trouble        | <input type="checkbox"/> Insomnia               | <input type="checkbox"/> Exposure to HIV (AIDS) |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Leakage of urine       | <input type="checkbox"/> Hot flashes            | <input type="checkbox"/> Drug abuse             |
| <input type="checkbox"/> Coughed up blood   | <input type="checkbox"/> Dizzy spells           | <input type="checkbox"/> Memory problems        |                                                 |

**For women only:**

Have you gone through menopause yet? Yes No If so, in what year? \_\_\_\_\_ (skip to section #2)

Are you using natural family planning? Yes No

Are you using any form of contraception (birth control)? Yes No If yes, what type? \_\_\_\_\_

Are you having any vaginal itching, irritation, or discharge? Yes No

Are you pregnant? Yes No Are you trying to get pregnant? Yes No

When was your last period? Are your periods regular? Yes No Heavy bleeding or cramps? Yes No

Have you had any of these symptoms daily for the last two weeks? Bloating, pelvic/abdominal pain, difficulty eating, feeling full quickly, frequent or urgent need to urinate? Yes No

2) **Mental Health:** Since your last exam have you had any of the following?

- |                                        |                                              |                                              |                                         |
|----------------------------------------|----------------------------------------------|----------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Unusual fears | <input type="checkbox"/> Feeling stressed    | <input type="checkbox"/> Feelings of sadness | <input type="checkbox"/> Angry feelings |
| <input type="checkbox"/> Nervousness   | <input type="checkbox"/> Feeling overwhelmed | <input type="checkbox"/> Depression          |                                         |

Have you ever been for counseling or psychotherapy? Yes (in the past) Yes (currently) No

Do you take at least one day off every week? Yes No When was your last vacation (at least a week long)? \_\_\_\_\_

What do you do to relax?:

3) **Spiritual Health:** Please mark "Y" for Yes and "N" for No. Research has shown a strong connection between spiritual health and physical/mental health. Please answer the following questions to help us evaluate your overall health status.

Do you worry a great deal?  Does life seem empty?  Do you feel at peace?

Do you feel guilty or ashamed?  Do you feel restless much of the time?  Is your life joyful?

How often do you attend religious services during the year? (circle one) Never / Major holidays / Monthly / At least weekly

Do you consider yourself: Very religious / Fairly religious / Only slightly religious / Not at all religious/ Against religion

How much is religion (and/or God) a source of strength and comfort to you?

Not very much / Somewhat / Quite a bit / A great deal

4) **Lifestyle**

Do you exercise regularly (at least three times a week)? Yes No

If yes, how often? \_\_\_\_\_ For how long? \_\_\_\_\_

What type of exercise do you prefer or enjoy? \_\_\_\_\_

Have you been wearing seat belts in your car? Yes No

Would you like to discuss any issues related to drug/substance abuse? Yes No

Are you using tobacco? Yes No If yes, how much?

Do you drink alcohol? Yes No If yes, how much?

Have you ever felt that you ought to cut down on your drinking? Yes No

Have people annoyed you by criticizing your drinking? Yes No

Have you ever felt bad or guilty about your drinking? Yes No

Have you ever had a drink in the morning to steady your nerves or to help with a hangover? Yes No

If you are married, how would you rate your marriage between 1 and 10 (1 being worst, 10 being best)? \_\_\_\_\_

Have you done anything in the last month to strengthen your marriage? Yes No Not sure

Do you identify yourself as gay (homosexual/lesbian)? Yes No

Have you been hit by anyone in your family? Yes No Have you ever been hurt sexually? Yes No

Have you ever suffered from physical or emotional abuse? Yes No

Would you like an AIDS (HIV) test? Yes No

Have you had any major stresses or changes in your life since your last exam? If so, please describe?

5) Have you been hospitalized, had surgery, or seen any other doctors since your last exam? Yes No

6) Are there any other problems you have had recently that your doctor should know about?

7) Work History: Are you currently (circle one)? Working Disabled Retired

If you are working, what type of work do you do? \_\_\_\_\_

Do you have any health problems which you feel are due to your work? Yes No

In your work do you touch or breathe poisons/chemicals/fumes/dust? Yes No

8) Current Medications/Therapies (please list any prescription or non-prescription medicines or treatments you are using, including vitamins, herbs, and alternative therapies):


9) If you are a new patient, please tell us about your family health history.

	Living? Yes/No	Age	Health Problems
Father			
Mother			
Brothers/Sisters			
Grandparents			