Cary Healthcare Associates, P.A.

Adult Health Questionnaire Form

Patient Name: ______________________________ Date: __________

Date of birth: ______________

Your Current Health

Please list your current medical conditions and medications you take on a regular basis.

Illness/Condition	Medications	Dose/Frequency

Drug Allergies: ____

Other Allergies: ____

Health Maintenance

Immunizations/Screening Tests:
When did you last have the following? Please include date.
Circle results for each test.

Tdap/Td vaccination______________
Pneumovax vaccination____________
Prevnar vaccination______________
Shingles vaccination_____________
Gardasil/HPV vaccination_________
Hepatitis B vaccination__________
Flu vaccination__________________

Colonoscopy__________ Normal or Abnormal
PSA_____________ Normal or Abnormal
Eye Exam__________ Normal or Abnormal
Stress Test_________ Normal or Abnormal
Bone Density________ Normal or Abnormal
Sleep Study_________ Normal or Abnormal
Mammogram_________ Normal or Abnormal
Pap Smear__________ Normal or Abnormal

Medical/Surgical History:

Please list all surgeries and dates if known:

____

____

Please list all hospitalizations and dates if known:

____

____

Please list all doctors that you currently see:

____

____

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Family History:

Who in your family has had: (ex: Father, Mother, Brother, Sister, etc.)

High Blood Pressure: ____________________
Heart Attack: ____________________
Stroke: ____________________
Cancer:(Please list what type) ____________________
Alcohol abuse: ____________________

Diabetes: ____________________
Thyroid Disease: ____________________
Glaucoma: ____________________
Depression: ____________________

Other serious illness in the family: ____________________

Social History:

Marital Status: (circle one) Single Married Widowed Divorced

Do you have children? Yes or No Number: ____________________

Employment status (circle one) Working Retired Disabled
Occupation: ____________________

Do you smoke? Yes or No
If no, did you ever smoke regularly and quit? Yes or No Year Quit: __________
If yes, how many cigarettes a day do you smoke? ____________________
When did you start smoking?

____

Do you drink beer, wine, or liquor? Yes or No
If yes, how many drinks per day/week? ____________________

Do you have or had a problem with drug abuse? Yes or No

Do you always wear a seatbelt? Yes or No

How many times a week do you exercise? ____________________

Do you work regularly out in the sun? ____________________

Advance Directives:

Do you have a Living Will? Yes or No
Do you have a Power of Attorney for healthcare? Yes or No
If yes, Name/Phone #____________________