

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?**

Tetanus vaccination_____	Colonoscopy_____
Pneumonia vaccination_____	PSA_____
Shingles vaccination_____	Eye Exam_____
Gardasil/HPV vaccination_____	Stress Test_____
Hepatitis B vaccination_____	Bone Density_____
Flu vaccination_____	Sleep Study_____
Tdap vaccination_____	Mammogram_____
PPD_____	Pap Smear_____

**Medical 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:**

**Have any of your blood relatives had any of the following?  
Who?**

High Blood Pressure: \_\_\_\_\_ Diabetes: \_\_\_\_\_  
Heart Attack: \_\_\_\_\_ Thyroid Disease: \_\_\_\_\_  
Stroke: \_\_\_\_\_ Glaucoma: \_\_\_\_\_  
Cancer: \_\_\_\_\_ Depression: \_\_\_\_\_  
Alcohol abuse: \_\_\_\_\_  
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 # \_\_\_\_\_