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 #_____