Adult Health History Questionnaire

Name:

Date Of Birth: / / **Today's Date:** / /

Please review the sections on both sides of this form. If this is your first visit to this physician, please fill this out in full. If you are not a new patient to this physician please update this form with any new information since your last visit. In all cases please complete the Review Of Symptoms And Health Problems section below.

Inglewood Family Health, PLLC

FAMILY

☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed	Next of Kin
Number of Children	Ages of Children	Occupation

REVIEW OF SYMPTOMS AND HEALTH PROBLEMS

What specific HEALTH PROBLEMS do you want to talk about when you are seen in the clinic?

Please mark any of the following symptoms that are CURRENTLY affecting you:

CONSTITUTIONAL
- ☐ Fever
- ☐ Fatigue
- ☐ Weight change ☐ Gain ☐ Loss
- ☐ Other:

HEAD, EYES, EARS, NOSE, THROAT
- ☐ Severe headaches
- ☐ Ear or hearing trouble
- ☐ Vision changes
- ☐ Other:

RESPIRATORY/LUNGS
- ☐ Daily cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Other:

HEART
- ☐ Chest pain
- ☐ Heart palpitations (skipped beats)
- ☐ Other:

VASCULAR
- ☐ Leg swelling
- ☐ Clotting problems
- ☐ Other:

STOMACH/INTESTINAL
- ☐ Frequent nausea or vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Other:

IMMUNOLOGY
- ☐ Food allergies
- ☐ Environmental allergies
- ☐ Other:

METABOLIC/ENDOCRINE
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Cold intolerance ☐ Heat intolerance
- ☐ Other:

NERVOUS SYSTEM
- ☐ Dizziness
- ☐ Excessive nervousness
- ☐ Other:

DERMATOLOGY/SKIN
- ☐ Rashes
- ☐ Itching
- ☐ Other:

BONES/JOINTS/MUSCLES
- ☐ Joint pain or swelling
- ☐ Muscle weakness
- ☐ Other:

BLOOD
- ☐ Excessive bleeding
- ☐ Excessive bruising
- ☐ Other:

URINARY
- ☐ Blood in urine
- ☐ Unusual discharge
- ☐ Leakage of urine
- ☐ Erectile Dysfunction
- ☐ Other:

GYNECOLOGY
- ☐ Changes in menstrual flow
- ☐ Excessive cramping
- ☐ Vaginal discharge
- ☐ Other: