Please complete form as completely as possible, prior to your appointment.

ADULT HEALTH QUESTIONNAIRE

(Confidential Medical Intake Form)

Patient Name: _____
Date of Birth: _____ **Age:** _____ **Sex at Birth:** ☐ Male ☐ Female ☐ Intersex
Gender Identity: _____
Date of Visit: _____
Primary Care Provider: _____
Pharmacy (Name/Location): _____

Emergency Contact: _____
Relationship: _____ Phone: _____

I. REASON FOR VISIT

☐ Annual physical
☐ Follow-up
☐ New patient visit
☐ Medication refill
☐ Specific concern (describe):

II. CURRENT SYMPTOMS (Check all that apply)

General

☐ Fever
☐ Chills
☐ Fatigue
☐ Weight loss
☐ Weight gain
☐ Night sweats

Cardiovascular

☐ Chest pain
☐ Palpitations
☐ Shortness of breath
☐ Swelling in legs
☐ High blood pressure

Respiratory

☐ Cough
☐ Wheezing
☐ Asthma
☐ Sleep apnea

Gastrointestinal

☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Abdominal pain
☐ Heartburn

Genitourinary

☐ Pain with urination
☐ Blood in urine
☐ Urinary frequency
☐ Incontinence

Musculoskeletal

☐ Joint pain
☐ Muscle pain
☐ Back pain
☐ Arthritis

Neurological

☐ Headaches
☐ Dizziness
☐ Numbness/tingling
☐ Seizures
☐ Memory concerns

Mental Health

☐ Anxiety
☐ Depression
☐ Mood swings
☐ Sleep difficulty
☐ Suicidal thoughts (current/past)
☐ History of trauma

III. PAST MEDICAL HISTORY

(Check all that apply)

☐ Hypertension
☐ Diabetes
☐ High cholesterol
☐ Heart disease
☐ Stroke
☐ Asthma/COPD
☐ Thyroid disorder
☐ Cancer (type/year): _____
☐ Chronic kidney disease
☐ Liver disease
☐ Autoimmune disorder
☐ Chronic pain condition
☐ Seizure disorder
☐ HIV/AIDS
☐ Hepatitis
☐ Mental health diagnosis (specify): _____

Other conditions:

IV. SURGICAL HISTORY

Procedure | Year | Hospital/Location
_____ | _____ | _____
_____ | _____ | _____

V. HOSPITALIZATIONS (Non-surgical)

Reason | Year
_____ | ____
_____ | ____

VI. ALLERGIES

☐ No known allergies

Medication Allergies:
Drug: _____ Reaction: _____

Food Allergies:

Environmental Allergies:

VII. CURRENT MEDICATIONS

Medication | Dose | Frequency | Prescribing Provider
_____ | ____ | _____ | _____
_____ | ____ | _____ | _____

☐ Over-the-counter medications
☐ Vitamins/Supplements
☐ Herbal remedies

VIII. FAMILY HISTORY

(Indicate relationship)

☐ Heart disease
☐ Hypertension
☐ Diabetes
☐ Cancer (type): _____

☐ Mental illness
☐ Substance use disorder
☐ Stroke
☐ Alzheimer's/Dementia

Other: _____

IX. SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed
Occupation: _____
Living Situation: _____

Tobacco Use

☐ Never
☐ Former (quit year: ___)
☐ Current — packs/day: ___ years: ___

Alcohol Use

☐ None
☐ Occasional
☐ Moderate
☐ Heavy

Substance Use

☐ None
☐ Marijuana
☐ Opioids
☐ Cocaine
☐ Methamphetamine
☐ Other: _____

Exercise

☐ None
☐ 1–2x/week
☐ 3–5x/week
☐ Daily

Diet

☐ Balanced
☐ High sodium
☐ High sugar
Special diet: _____

X. PREVENTIVE HEALTH

☐ Flu vaccine (year: ___)
☐ COVID vaccine
☐ Tdap
☐ Pneumonia vaccine
☐ Shingles vaccine

Screenings:
☐ Colonoscopy (year: ___)
☐ Mammogram (year: ___)
☐ Pap smear (year: ___)
☐ Prostate exam (year: ___)
☐ Bone density

XI. WOMEN'S HEALTH (If applicable)

Age at first period: ___
Last menstrual period: ___
Pregnancies: ___
Complications: _____

XII. ADVANCE DIRECTIVES

☐ Living will
☐ Healthcare proxy
☐ Do not resuscitate (DNR)

XIII. FUNCTIONAL STATUS

☐ Independent in daily activities
☐ Needs assistance with: _____

☐ History of falls
☐ Use of assistive device

XIV. PATIENT SIGNATURE

I certify that the information provided is accurate to the best of my knowledge.

Patient Signature: _____
Date: _____

Provider Signature: _____
Date: _____