Canby Healthcare Clinic

Adult Health Questionnaire

Name: _____ Date of Birth: _____ Today's Date: _____

What do you prefer to be called? _____ Gender: ☐ Male ☐ Female

Are you currently: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ In a relationship

What health problem(s) are you seeking help for? _____

_____

_____

Personal and Family Medical History Checklist Allergies: _____

	You	Family	Please elaborate:
Stroke or heart attack			
High Blood Pressure			
Heart disease			
Liver disease			
Kidney disease			
Diabetes or prediabetes			
Fibromyalgia			
Back problems			
Chronic pain			
High Cholesterol			
Head trauma			
Seizures			
Cancer			
Asthma or COPD			
Intestinal problems			
Reproductive issues			
Surgeries:			

List ALL current medications, over the counter medications and supplements: _____

_____

_____

_____

_____

Health Prevention:

Have you had?	No	Yes	When?
Basic labs			
Mammogram			
Pap smear			
DEXA scan			
Colonoscopy			

Partner and Relationship Health:

Are you sexually active? ☐ Yes ☐ No

Do you feel safe in your present relationship?

☐ Yes ☐ No

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For Women Only: Date of last menstrual period: _____Birth control method? _____
Are you currently pregnant or suspect you may be? _____ Are you planning a pregnancy?_____
How many times have you been pregnant? _____ How many live births?_____

Social History

Do you use:	No	Yes	How much?	When did you start?	Date last used?
Alcohol					
Tobacco					
Marijuana					
Methamphetamines					
Heroin/Opiates					
Other:					

Occupational History Highest level of education: _____

Are you currently? ☐ Working ☐ Not working by choice ☐ Unemployed ☐ Disabled ☐ Retired

Occupation: _____Where do you work? _____

Are you a veteran? ☐ Yes ☐ No If yes, what branch and when? _____

Please check off any of the following problems that apply to you: **__ No problems**

General
__ Fever
__ Sweats
__ Weight gain or loss

Allergy
__ Seasonal symptoms
__ Itchy eyes
__ Nasal congestion
__ Eczema

Cardiopulmonary
__ Chest pain or pressure
__ Difficulty breathing
__ Ankle swelling
__ Palpitations

Head & Neck
__ Blurry or changing vision
__ Eye pain
__ Headaches
__ Ear pain
__ Hearing problems
__ Sore throat
__ Difficulty swallowing
__ Hoarseness

Gastrointestinal
__ Acid reflux
__ Nausea
__ Vomiting
__ Abdominal pain
__ Constipation
__ Diarrhea
__ Black or bloody stool
__ Hemorrhoids

Genitourinary
__ Urinary frequency
__ Painful urination
__ Blood in urine
__ Difficulty urinating
__ Incontinence
__ Waking at night to urinate
__ Problems with sex
__ Exposure to sexually transmitted disease
__ Vaginal discharge
__ Lesions or sores in groin area

Respiratory
__ Coughing
__ Wheezing
__ Short of breath
__ Short of breath with exertion
__ Dizziness or chest tightness with exertion

Skin
__ Rash
__ Changing mole
__ Itching
__ Slow-healing wound

Neurologic
__ Numbness in extremities
__ Tingling
__ Weakness
__ Dizziness
__ Headaches
__ Memory or cognitive problems

Nutrition
__ Food intolerances
__ Eating disorder

Mental Health
__ Insomnia
__ Guilt
__ Depression
__ Anxiety
__ Post-traumatic stress
__ Thoughts of suicide
__ Violence in your home
__ Changes in eating habits
__ Addiction

Musculoskeletal
__ Joint pain
__ Back pain
__ Swelling in joint(s)
__ Arthritis
__ Fractured bone

Please comment on any other medical problems you would like us to be aware of: