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? ____

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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: ____________________

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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	**Gastrointestinal** __ Acid reflux __ Nausea __ Vomiting __ Abdominal pain __ Constipation __ Diarrhea __ Black or bloody stool __ Hemorrhoids	**Respiratory** __ Coughing __ Wheezing __ Short of breath __ Short of breath with exertion __ Dizziness or chest tightness with exertion	**Nutrition** __ Food intolerances __ Eating disorder
Allergy __ Seasonal symptoms __ Itchy eyes __ Nasal congestion __ Eczema			**Mental Health** __ Insomnia __ Guilt __ Depression __ Anxiety __ Post-traumatic stress __ Thoughts of suicide __ Violence in your home __ Changes in eating habits __ Addiction
Cardiopulmonary __ Chest pain or pressure __ Difficulty breathing __ Ankle swelling __ Palpitations	**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	**Skin** __ Rash __ Changing mole __ Itching __ Slow-healing wound	
Head & Neck __ Blurry or changing vision __ Eye pain __ Headaches __ Ear pain __ Hearing problems __ Sore throat __ Difficulty swallowing __ Hoarseness		**Neurologic** __ Numbness in extremities __ Tingling __ Weakness __ Dizziness __ Headaches __ Memory or cognitive problems	**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: