MINOR & JAMES MEDICAL

We ask that you take some time with this questionnaire so we can better help you. If any questions are difficult to answer please feel free to ask your doctor during your visit.

Today's Date ______________________________

Your Name ______________________________ Next of Kin ______________________________

Date of Birth ____________________ Age ________ Female _____ Male ______ Marital Status _____

Home Phone Number ______________________________ Work Phone Number ______________________________

Occupation ______________________________ Referred by ______________________________

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

____

2. **ALLERGIES:** Are you allergic to or have you had a "bad reaction" to any medicines or other substances?

No ___ If yes, list the medicines ______________________________

3. What **PRESCRIPTION** medicines do you presently take? (List doses and frequency) ______________________________

____

____

4. Do you take any **NON-PRESCRIPTION** medicines? For example: laxatives, vitamins, aspirin, antacids, or cold remedies?

No ___ If yes, please list ______________________________

5. **HOSPITALIZATIONS** or **SURGERIES**: (Type of illness / operation / place / year) ______________________________

____

6. **VACCINATIONS**: (Include year if known) Measles _________ Mumps _________ Rubella _________ Tetanus _________

Polio _________ Influenza _________ Hepatitis _________ Pneumonia _________

7. **YOUR HEALTH HISTORY:**

Have you had any of the following?

YES	NO	
___	___	Anemia
___	___	Asthma
___	___	Cancer, if yes, kind and date __________ ____________________
___	___	Emphysema
___	___	Heart disease
___	___	High blood pressure
___	___	Kidney stones
___	___	Liver disease, jaundice, hepatitis
___	___	Migraine
___	___	Serious injury or accident
___	___	Sugar diabetes
___	___	Thyroid gland trouble
___	___	Tuberculosis or positive skin test to TB
___	___	Sexually transmitted disease
___	___	Transfusions

8. **WOMEN'S** HEALTH HISTORY:

Number of pregnancies

Age of first menstrual period __________

Age of menopause __________

Current types of contraception ____________________

____

Have you been on the pill? __________ When? __________

Have you been on estrogen replacement?

Yes _____ No _____

Calcium Intake? Yes _____ No _____

Diet or Pills? Yes _____ No _____

9. **HABITS** (Please Circle)

Tobacco: Cigarettes Pipe Cigar Chew

Number of years ________ Daily amount ________

Caffeine: Number of cups/day ______ Type _________

Alcohol: None Beer Wine Other Liquors

Amount per week ____________________

Hours of sleep per night ____________________

Number of meals per day ____________________

Do you use other drugs? Yes _____ No _____

Exercise? Yes _____ No _____

Use Seatbelts? Yes _____ No _____

Use Bicycle helmets? Yes _____ No _____

Smoke Detectors? Yes _____ No _____

PLEASE CONTINUE ON THE OTHER SIDE OF SHEET

ADULT HEALTH QUESTIONNAIRE

10. **SYMPTOMS**: Please mark (X) in the appropriate box indicating if you now have these symptoms by either Yes or No

Yes	No	**CONSTITUTIONAL**
☐	☐	Unexplained Fever
☐	☐	Fatigue
☐	☐	Night Sweats
☐	☐	Other______________________

Yes	No	**HEAD, EYES, EARS, NOSE, THROAT**
☐	☐	Severe Headaches
☐	☐	Ear or Hearing Trouble
☐	☐	Vision Changes
☐	☐	Other______________________

Yes	No	**RESPIRATORY/LUNGS**
☐	☐	Daily Cough
☐	☐	Wheezing
☐	☐	Shortness of Breath
☐	☐	Other______________________

Yes	No	**HEART**
☐	☐	Chest Pain
☐	☐	Heart Palpitations (skipped beats)
☐	☐	Other______________________

Yes	No	**VASCULAR**
☐	☐	Leg Vein Trouble
☐	☐	Clotting Problems
☐	☐	Other_____________________

Yes	No	**STOMACH/INTESTINAL**
☐	☐	Frequent Nausea or Vomiting
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Other____________________

Yes	No	**URINARY**
☐	☐	Blood in Urine
☐	☐	Unusual Discharge
☐	☐	Other

Yes	No	**GYNECOLOGY**
☐	☐	Changes in Menstrual Flow
☐	☐	Excessive Cramping
☐	☐	Vaginal Discharge
☐	☐	Other____________________

Yes	No	**METABOLIC/ENDOCRINE**
☐	☐	Excessive Thirst
☐	☐	Excessive Hunger
☐	☐	Cold or Heat Intolerance
☐	☐	Other_______________________

Yes	No	**NERVOUS SYSTEM**
☐	☐	Dizziness
☐	☐	Excessive Nervousness
☐	☐	Other____________________

Yes	No	**DERMATOLOGY/SKIN**
☐	☐	Rashes
☐	☐	Itching
☐	☐	Other_____________________

Yes	No	**BONES/JOINTS/MUSCLES**
☐	☐	Joint Pain or Swelling
☐	☐	Muscle Weakness
☐	☐	Other___________________

Yes	No	**BLOOD**
☐	☐	Excessive Bleeding
☐	☐	Excessive Bruising
☐	☐	Other____________________

Yes	No	**IMMUNOLOGY**
☐	☐	Food Allergies
☐	☐	Environmental Allergies
☐	☐	Other

11. WHICH OF YOUR BLOOD RELATIVES HAD ANY OF THE FOLLOWING DISEASES:

Early coronary heart disease______________________________
Diabetes____
High blood pressure____________________________________
Mental or emotional disease_______________________________
Tuberculosis____
Alcohol or substance abuse_______________________________
Cancer:
Breast__________________Ovary________________
Colon__________________Prostate_______________

12. CHILDREN

Number of children________________________________
Health Status____________________________________