MAB
MEDICAL ASSOCIATES OF BREVARD
A Multi-Specialty Group Practice

ADULT HEALTH QUESTIONNAIRE

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____ **TODAY'S DATE:** _____

What would you like to talk to your doctor about today? _____

_____

MEDICAL HISTORY

Please list any medication allergies or reactions:

_____

_____

Please check to indicate if you have ever had the following conditions:

- ☐ Diabetes
- ☐ Kidney disease
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Arrythmia
- ☐ Eye problems – type: _____
- ☐ Other, please explain: _____
- ☐ High blood pressure
- ☐ Hepatitis
- ☐ Depression
- ☐ Coronary Artery Disease
- ☐ Sexually transmitted disease – type: _____
- ☐ Asthma
- ☐ Thyroid disease
- ☐ Emphysema
- ☐ Congestive Heart Failure
- ☐ Cancer – type: _____
- ☐ Heart attack
- ☐ Seizures

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery / reason for hospitalization / location	*Date*
_____	_____
_____	_____
_____	_____

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

_____

_____

When was your last physical?

_____

Please list all medications, including vitamins, herbal or natural supplements and prescription medications, which you are currently taking. Please note the dosage if possible.

Medication Name	*Dosage*

What pharmacy do you use for prescription medications?

_____

Are you currently receiving care from any other doctors, chiropractors, or other health care professionals? If yes, we would like to know whom so that we can coordinate your care:

Provider's name	*Condition they are treating you for*

Please note dates of your most recent immunizations:

	Approximate Date		*Approximate Date*
Tetanus	_____	Influenza	_____
Pneumonia	_____	Hepatitis B	_____
Other: _____	_____	Other: _____	_____

If you have had any of the following tests done, please note when the tests was done and what the results were, if known:

Test	*Approximate Date*	*Result*
Cholesterol	_____	
Pap smear/pelvic	_____	
Mammogram	_____	
Blood in stool	_____	
HIV	_____	
Colonoscopy	_____	
Hepatitis C	_____	

FAMILY HISTORY

Check any of the diseases that run in your family **and** please note who had it:

	None	Mother	Father	Sister	Brother	Grandmother (mother's side)	Grandfather (mother's side)	Grandmother (father's side)	Grandfather (father's side)	Child	Other (Please explain)
Alcoholism or Drug Use											
Cancer											
Cancer Type											
Diabetes											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Osteoporosis											
Mental Illness											
Stroke											
Thyroid Disease											
Other											

Other Comments:

_____

_____

_____

_____

HEALTH HABITS

Do you smoke or use any tobacco products?..... ☐ Yes ☐ No ☐ Quit

Number of cigarettes each day? _____

For how many years? _____

Other forms of tobacco used? _____

Do you drink alcohol?..... ☐ Yes ☐ No ☐ Quit

How much? _____

How often? _____

Have you ever felt that you should cut down on your drinking?..... ☐ Yes ☐ No

Have you regularly used other drugs?..... ☐ Yes ☐ No

If yes, are you still using them?..... ☐ Yes ☐ No

PERSONAL HISTORY

Are you currently married or living with a significant other? ☐ Yes ☐ No

Who lives with you at home?_____

Are you employed? ☐ Yes ☐ No

If yes, what kind of work do you do?_____

If no, is this by choice?___ Disability?____ Other reasons?_____

Do you exercise more than 2 times per week? ☐ Yes ☐ No

Do you often feel sad or depressed? ☐ Yes ☐ No

Do you feel there is something seriously wrong with your body? ☐ Yes ☐ No

Are you having money problems which limit your access to food, shelter or medical care? ☐ Yes ☐ No

In the last year, have there been any major changes in your life like marriage, divorce, death of a family member or close friend, illness or injury, or change in job situation? ☐ Yes ☐ No

SEXUAL HISTORY

Are you sexually active? ☐ Yes ☐ No

With: ☐ Men ☐ Women ☐ Both

Do you feel you are at risk for HIV/AIDS? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No

How many children do you have? _____

Do you use any form of birth control? ☐ Yes ☐ No

If yes, which type / brand? _____

WOMEN ONLY

Have you ever been pregnant? ☐ Yes ☐ No

How many times? _____

How many miscarriages? _____

How many abortions? _____

How many children do you have living? _____

Do you have menstrual periods? ☐ Yes ☐ No

If no, at what age did they stop? _____

If yes, are your periods regular? _____

OTHER COMMENTS:

_____

_____

_____

_____