Adair County
Health System
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HEALTH HISTORY QUESTIONNAIRE

Patient Name: **Date of Birth:** **MRN:**

PERSONAL HEALTH HISTORY: Do you have or have you had any of the following? Please elaborate on "Yes" answers in the comments section.

None	Y	N	Hepatitis C	Y	N	Comments:
Allergies	Y	N	High Cholesterol	Y	N	
Anemia	Y	N	High Blood Pressure	Y	N	
Anxiety	Y	N	Irritable Bowel Disease	Y	N	
Arthritis	Y	N	Kidney Disease	Y	N	
Asthma	Y	N	Liver Disease	Y	N	
Blood Clots	Y	N	Migraine Headaches	Y	N	
Cancer – Type	Y	N	Osteoporosis	Y	N	
COPD (Emphysema)	Y	N	Prostate Disease	Y	N	
Depression	Y	N	Stroke	Y	N	
Diabetes	Y	N	Stomach Ulcer	Y	N	
GERD (Heartburn)	Y	N	Seizure Disorder	Y	N	
Heart Problems	Y	N	Other	Y	N	

ALLERGIES: Do you have allergies to any medications, foods, or latex/adhesives? ☐ No ☐ Yes (please specify below)

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SURGICAL HISTORY: Please list all surgeries with month and year (please approximate the year if you can't recall the specific date).

Surgical Procedure	Month/Year	Surgical Procedure	Month/Year	Surgical Procedure	Month/Year
NONE		Hip Replacement		*FEMALE ONLY*	
Appendix removed		Knee Replacement		Breast Surgery	
Back/Spine Surgery		Liver Surgery		Cesarean Section	
Carpal Tunnel Release		Thyroid Surgery		Hysterectomy	
Cataract Removal		Tonsillectomy		Tubal Ligation	
Colon Surgery		*MALE ONLY*			
Gallbladder Removed		Prostate Surgery			
Heart Surgery		Other:		Other:	
Hernia Repair		Other:		Other:	

English--Adair County Medical Clinics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Español (Spanish)—Adair County Medical Clinics cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.
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English--ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 641-743-2123
Español (Spanish)--ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 641-743-2123
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HEALTH MAINTENANCE: Check if you have received the following, and the date of the most recent exam

EXAM	YEAR	EXAM	YEAR
None		GYN Exam/Pap Smear	
Breast Exam		Influenza Vaccination	
Cardiac Stress Test		Mammography	
Colonoscopy		Physical Exam	
DEXA Bone Scan		Pneumococcal Vaccination	
Eye Exam		Pulmonary Function Test	

CURRENT MEDICATIONS: Please list your current medications below. Please include all non-prescription medications, vitamins, and herbal remedies. Please list dosages if known.

Preferred Pharmacy ________________________________ **Phone #:** ____________________

MEDICATION	DOSE	TAKE HOW OFTEN?

FAMILY HISTORY: Check if any family member(s) had any of the following conditions:

Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Alcoholism							
Asthma							
CAD (Heart Attach/Heart Disease)							
Cancer – Type:							
Depression							
Diabetes							
Hyperlipidemia (High Cholesterol)							
Hypertension (High Blood Pressure)							
Irritable Bowel Disease							
Mental Illness							
Tuberculosis							
Other:							

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FAMILY HISTORY: Check if any family member(s) had any of the following conditions:

Pregnancy	Term		Preterm		Abortion		Living		Delivery Date
1	Yes	No	Yes	No	Yes	No	Yes	No	
2	Yes	No	Yes	No	Yes	No	Yes	No	
3	Yes	No	Yes	No	Yes	No	Yes	No	
4	Yes	No	Yes	No	Yes	No	Yes	No	
5	Yes	No	Yes	No	Yes	No	Yes	No	
6	Yes	No	Yes	No	Yes	No	Yes	No	

SOCIAL HISTORY:

Occupation:			**Employer:**	
Children	☐ Yes	☐ No	Females:	Males:
Tobacco/Nicotine Use Former/Year Quit:	☐ Never	☐ Daily	☐ Socially	Packs/Day:________
Alcohol Use Former/Year Quit: _________	☐ Never	☐ Daily	☐ Socially	Drinks/Day: _______ ☐ Beer ☐ Wine ☐ Liquor Other: ______________________________
Drug Use Former/Year Quit: _________	☐ Never	☐ Daily	Drugs Used: ____	

PEDIATRIC/DEPENDENT ADULT PATIENTS:

Patient resides with:

Primary: ☐ Mother ☐ Father ☐ Both Parents ☐ Other: _________________________
Secondary: ☐ Mother ☐ Father ☐ Other: _____________________

Mother's/Caregiver's Occupation: ______________________________ **Father's/Caregiver's Occupation:** ______________________________

Parent's/Caregiver's Relationship

☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐Separated

Childcare/Dependent Adult Care

☐ Mother ☐Father ☐Sibling ☐Grandparent ☐Nanny ☐Daycare ☐Primary Caregivers

Tobacco Exposure: ☐ Yes ☐ No **Smokers at Home:** ☐ Yes ☐ No **Is Patient a Current Smoker?** ☐ Yes ☐ No

Patient Signature: ____ Date: ___________________________________

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