# NEW LIFE FAMILY MEDICINE, LLC
# ADULT HEALTH QUESTIONNAIRE

Name: _____ DOB:_____ Age:_____ Sex: ☐ M ☐ F

Who was your previous primary care provider(s)? _____

What is your preferred pharmacy? _____

**CURRENT MEDICATIONS** (Please bring in your medications if available)

| Name of Medication | Strength of Medication | Dosing Instructions |
|---|---|---|
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**ALLERGIES**

☐ No Known Allergies ☐ Medication Allergies ☐ Environmental/Seasonal ☐ Latex

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |

**PAST MEDICAL HISTORY** (Check all that apply)

☐ Acid Reflux/GERD ☐ Bleeding Disorders ☐ Hearing Loss ☐ Stroke
☐ ADHD ☐ Cancer ☐ Heart Disease ☐ Thyroid Disease
☐ Alcoholism ☐ Depression ☐ High Blood Pressure ☐ Chronic Pain
☐ Allergies ☐ Diabetes ☐ High Cholesterol ☐ Osteoporosis
☐ Anemia ☐ Emphysema/Bronchitis/COPD ☐ Irritable Bowel ☐ Liver Disease
☐ Anxiety ☐ Epilepsy/Seizure Disorder ☐ Kidney Disease ☐ Headaches
☐ Arthritis ☐ Glaucoma/Cataracts ☐ Asthma
☐ Other (please list) _____

**PAST SURGICAL HISTORY**

| Date of Surgery (Operations) | Type of Surgery (Operations) |
|---|---|
| | |
| | |
| | |
| | |
| | |

**FAMILY HISTORY** (Check all that apply)

☐ Asthma ☐ Dementia/Alzheimer's ☐ Depression ☐ Diabetes

☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Thyroid Disease

☐ Stroke ☐ Cancer (Please specify) _____

☐ Other (Please list) _____

**SOCIAL HISTORY**

*Personal History*

Marital Status ☐ Single ☐ Significant other ☐ Married ☐ Divorced ☐ Widowed
Name of Significant Other/Spouse (if applicable): _____

Children: ☐ Yes ☐ No Number of Sons _____ Number of Daughters _____
Name(s) and Age(s) of Child(ren): _____

Living Situation: ☐ Live Alone ☐ With Significant Other/Spouse ☐ With Children/Family Members ☐ Other
Occupation: _____
Hobbies/Interests: _____

*Tobacco*

Have you ever smoked? ☐ Yes ☐ No If yes, what do (did) you smoke? _____

Are you still smoking? ☐ Yes ☐ No

If no: How many years ago did you quit? _____ For how many years did you smoke? _____ How many packs/day did you smoke? _____

If yes: How many years have you smoked? _____ How many packs/day do you smoke? _____

Have you ever tried to quit? ☐ Yes ☐ No

*Alcohol*

Do you drink alcohol including beer, wine, or other alcohol? ☐ Yes ☐ No
If yes, please specify frequency:

☐ Daily ☐ Almost Daily (4-6 times per week) ☐ 1-3 times per week ☐ Less than once per week

*Illicit Drugs*

Do you use any drugs or prescription medications not prescribed to you? ☐ Yes ☐ No
(including marijuana, cocaine, amphetamines, pain or anxiety medications, etc.)
If yes, please specify type of drug and frequency of use: _____

*Diet/Activity*

Are you on any special diet? ☐ Yes ☐ No
If yes, how would you describe your diet? (South Beach, Atkins, low calorie, renal, diabetic, low sodium, low fat, high protein, etc.) _____

Do you currently participate in any regular activity to improve or maintain your physical fitness (either on your own or in a formal class)? ☐ Yes ☐ No If yes, please describe: _____
_____

*Health Planning*

Do you have Advanced Directives in place? ☐ Yes ☐ No

☐ Living Will ☐ Durable Power of Attorney ☐ Health Care Proxy ☐ Advanced Directives

## HEALTH MAINTENANCE

Please provide the dates and results of the following immunizations, examinations, and tests to the best of your ability. If you have not had one of these services indicate N/A (not applicable).

*All Patients:*

| | | | | |
|---|---|---|---|---|
| Last Tetanus Booster | ☐ Within the past 10 yrs. | ☐ More than 10 yrs. Ago | | ☐ Unknown |
| Last Eye Exam | Date: _____ | ☐ Normal | ☐ Abnormal | ☐ Unknown |
| Last Hearing Exam | Date: _____ | ☐ Normal | ☐ Abnormal | ☐ Unknown |
| Last sigmoid/colonoscopy/ or stool test | Date: _____ | ☐ Normal | ☐ Abnormal | ☐ Unknown |
| Last DEXA Bone Scan | Date: _____ | ☐ Normal | ☐ Abnormal | ☐ Unknown |
| Last Pneumonia Vaccine | Date: _____ | | | |
| Flu vaccine this season? | ☐ Yes ☐ No | | | |

*Women:*

| | | | | |
|---|---|---|---|---|
| Last PAP Smear | Date: _____ | ☐ Normal | ☐ Abnormal | ☐ Unknown |
| Last Mammogram | Date: _____ | ☐ Normal | ☐ Abnormal | ☐ Unknown |

*Men:*

| | | | | |
|---|---|---|---|---|
| Last Prostate Specific Antigen (PSA) | Date: _____ | ☐ Normal | ☐ Abnormal | ☐ Unknown |
| Last Prostate Exam | Date: _____ | ☐ Normal | ☐ Abnormal | ☐ Unknown |

## CONCERNS

Please list any concerns regarding the health of this child in the space provided.

_____
_____
_____
_____
_____
_____
_____
_____

**Name and Relationship of Person Completing Form (print):**

_____

Signature _____ Date: _____

We would like to thank you for taking the time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit.