Patient's Name: _____ **DOB:** _____ **Date Completed:** _____

Beatrice Community Hospital and Health Center Clinics

ADULT MEDICAL HISTORY QUESTIONNAIRE

Please complete the following information which will be kept in your medical record.

HOSPITALIZATIONS:

Date	Reason

SURGERIES:

Date	Reason

PHARMACY PREFERENCE: _____

CURRENT MEDICATIONS: (Include contraception, hormone replacement therapy, and vitamins).

[ ] No Current Medications Please complete the following or provide separate document of medications.

Medication	Dose	Taken How Often

Medication	Dose	Taken How Often

ALLERGIES: [ ] No Known Allergies (Please include any medication, food, or environmental allergy).

Allergy	Reaction

Allergy	Reaction

PERSONAL PAST MEDICAL HISTORY:

[ ] Alcoholism
[ ] Allergies/Hay Fever
[ ] Anemia
[ ] Anxiety
[ ] Arthritis
[ ] Artificial Implant
[ ] Asthma
[ ] Bladder infection
[ ] Bleeding problems, including blood clots
[ ] Blood transfusions
[ ] Bronchitis
[ ] Cancer; type _____
[ ] Crohns disease
[ ] Diabetes
[ ] Elevated cholesterol
[ ] Fibromyalgia
[ ] Glaucoma
[ ] Gout
[ ] Headaches
[ ] Heart disease
[ ] Heart murmur
[ ] Heartburn
[ ] Hepatitis
[ ] High blood pressure
[ ] Irritable bowel syndrome
[ ] Kidney disease
[ ] Kidney infection
[ ] Liver disease
[ ] Lung disease
[ ] Mental illness, including Depression
[ ] Mitral valve prolapse
[ ] MRSA
[ ] Neurologic disease
[ ] Osteopenia
[ ] Osteoporosis
[ ] Pneumonia
[ ] Poor circulation
[ ] Prostate disease
[ ] Risk of AIDS
[ ] Serious injury or accidents
[ ] Skin problems, including Moles
[ ] Sleep Apnea
[ ] Stroke
[ ] Thyroid problems
[ ] Tuberculosis
[ ] Venereal disease
[ ] Other _____
[ ] Other _____
[ ] Other _____

FAMILY HISTORY: Has anyone in your *family* been diagnosed with the following (indicate who by using the following):
M – Mother; F – Father; S – Sibling; C – Child; GM – Grandmother; GF – Grandfather; A – Aunt; U – Uncle

[ ] Alcoholism _____
[ ] Asthma _____
[ ] Bleeding problem, including blood clots _____
[ ] Cancer, breast _____
[ ] Cancer, other _____ Type: _____
[ ] Diabetes _____
[ ] Headaches _____
[ ] Heart disease _____
[ ] High blood pressure _____
[ ] Kidney disease _____
[ ] Mental illness, including Depression _____
[ ] Osteoporosis _____
[ ] Skin problems, including Moles _____
[ ] Stroke _____
[ ] Thyroid problems _____
[ ] Other _____

-OVER-

Patient's Name: _____DOB: _____Date Completed:_____

ADVANCED DIRECTIVES (complete only if patient is 19 or older):

Do you have an Advanced Directive? (Living Will or Durable Power of Attorney for Healthcare): [ ] Yes [ ] No

If yes, please provide us with a copy.

If no, would you like additional information about Advanced Directives? [ ] Yes [ ] No

DOMESTIC SCREENING (complete only if patient is 16 or older):

Do you ever feel unsafe in your current relationship, or is there someone from a past relationship (past 6 months) who makes you feel unsafe? [ ] Yes [ ] No

In your present living situation, within the past 6 months, have you been intentionally hurt or controlled by anyone? This includes being hit, sexually abused, kicked, pushed, threatened, or called names. [ ] Yes [ ] No

Would you like to speak privately about this issue to the clinic nurse or medical provider? [ ] Yes [ ] No

SOCIAL HISTORY:

Martial Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed Who do you currently live with? _____

Do you have children? [ ] Yes [ ] No If yes, how many: _____

Are you employed: [ ] Yes [ ] No If yes, [ ] Full-time [ ] Part-time. Occupation: _____

If no, are you: [ ] unemployed [ ] student [ ] homemaker [ ] retired [ ] disabled [ ] stay-at-home parent

When teaching is needed regarding your medical care, which method do you prefer?

[ ] Written information [ ] Demonstration [ ] Audiovisual [ ] One-one-One Instruction [ ] No Preference [ ] Other: _____

Do you [ ] smoke or use [ ] smokeless tobacco? If Yes, how long: _____ Number of packs per day: _____ Quit Date: _____

Do you drink alcohol? [ ] Yes [ ] No. If yes, how long: _____ Amount consumed: _____ Quit Date: _____

Do you use recreational/street drugs? [ ] Yes [ ] No. If yes, what type _____ How long: _____

Do you drink caffeinate beverages: [ ] Yes [ ] No. How many per day/week: _____

Do you wear a seatbelt? [ ] Yes [ ] No

Describe your diet: [ ] Poor [ ] Average [ ] Good. Recent Weight: [ ] Gain or [ ] Loss. Amount: _____. Intentional: [ ] Yes [ ] No

Do you exercise? [ ] Yes [ ] No If yes, please list type and how often: _____

Primary language spoken by patient: _____. By other family members: _____

Please list any cultural or religious preferences: _____

ADULT IMMUNIZATIONS: Please provide year of last:

Flu Shot: _____ Pneumonia Shot: _____ Tetanus Shot: _____ Hepatitis B Shot: _____

CHILDREN'S IMMUNIZATIONS: Please provide immunization card.

***FEMALE PATIENTS ONLY:* GYNECOLOGICAL HISTORY:**

Age of first period: _____
Date of most recent period: _____
Are your periods regular: [ ] Yes [ ] No
How long do they last: _____
Number of days from start of one period to start of next period: _____

Number of pregnancies: _____
Number of children born alive: _____
Number of miscarriages: _____
Number of abortions: _____
Did you deliver [ ] Vaginally
[ ] C-section

Are you sexually active? [ ] Yes [ ] No
Birth control method: _____
Date of last mammogram: _____
Age of menopause: _____
If menopausal, hormone replacement therapy? [ ] Yes [ ] No

Date of last Pap Smear: _____
Normal: [ ] Yes [ ] No
Have you had any treatment to your cervix: [ ] Yes [ ] No
If yes, when _____
Type of treatment:
[ ] Colposcopy [ ] Laser
[ ] Cryosurgery [ ] LEEP

Do you have any of the following:

Bleeding between periods: [ ] Yes [ ] No
Heavy menstrual cycles: [ ] Yes [ ] No
Bleeding after intercourse: [ ] Yes [ ] No
Pain with periods: [ ] Yes [ ] No
Uncontrolled loss of urine with coughing or at other times: [ ] Yes [ ] No
If yes, for how long: _____

Infection in your female organs: [ ] Yes [ ] No
Venereal disease [ ] Yes [ ] No
Herpes: [ ] Yes [ ] No
Genital Warts: [ ] Yes [ ] No