PHYSICIAN GROUP
ORLANDO HEALTH

ADULT HEALTH QUESTIONNAIRE

Orlando Health Endocrinology

PATIENT NAME:	DOB:	Date:

I. ACTIVE PROBLEMS

I. List any illnesses for which you are now being treated at this office or any other physician's office.

2. PAST MEDICAL HISTORY

1. Have YOU ever had any of the following problems?

YES	NO	PROBLEM	MONTH/YEAR	YES	NO	PROBLEM	MONTH/YEAR
☐	☐	Arthritis/Rheumatism/Gout/Lupus	/	☐	☐	Stomach Trouble/Ulcers	/
☐	☐	Asthma (wheezing)	/	☐	☐	Bowel Trouble/Colitis	/
☐	☐	Hay Fever/Sinus Trouble	/	☐	☐	Any type of Cancer/Tumor	/
☐	☐	Emphysema/Bronchitis/Constant Cough	/	☐	☐	Epilepsy (fits, seizures, convulsions)	/
☐	☐	Pneumonia/Pleurisy	/	☐	☐	Stroke or Paralysis	/
☐	☐	Rheumatic Fever/Heart Murmur	/	☐	☐	Thyroid Disorders/Goiter	/
☐	☐	Coronary Artery Disease/Heart Attack/Angina	/	☐	☐	High Blood Pressure/Hypertension	/
☐	☐	Enlarged Heart/Congestive Heart Failure	/	☐	☐	Venereal Disease (Syphilis, Gonorrhea, Chlamydia) or PID	/
☐	☐	Tuberculosis	/	☐	☐	HIV Infections/ AIDS	/
☐	☐	Blood Clots in your Legs or Lungs	/	☐	☐	Yellow Jaundice/Hepatitis/Liver Cirrhosis	/
☐	☐	Diabetes (sugar)	/	☐	☐	Kidney or Bladder Trouble	/
☐	☐	Anemia (low, weak blood)	/	☐	☐	Osteoporosis	/
☐	☐	Bleeding Tendency/Unusual Bruising	/	☐	☐	Migraine Headaches	/

2. List hospitalizations, starting with most recent:

Illness/Injury (Location)	Onset/Injury Date	Hospital/Location/Physician

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3. PAST SURGICAL HISTORY

1. List any surgeries YOU have had and the date.

SURGERY	HOSPITAL	DATE

4. FAMILY HISTORY

1. Check (√) relationship as indicated

	Relationship	Age if Living	Age at Death	Illness and/or cause of death
☐	**Father**			
☐	**Paternal Grandfather**			
☐	**Paternal Grandmother**			
☐	**Paternal Aunt 1**			
☐	**Paternal Aunt 2**			
☐	**Paternal Uncle 1**			
☐	**Paternal Uncle 2**			
☐	**Mother**			
☐	**Maternal Grandfather**			
☐	**Maternal Grandmother**			
☐	**Maternal Aunt 1**			
☐	**Maternal Aunt 2**			
☐	**Maternal Uncle 1**			
☐	**Maternal Uncle 2**			
☐	**Brother 1**			
☐	**Brother 2**			
☐	**Brother 3**			
☐	**Brother 4**			
☐	**Sister 1**			
☐	**Sister 2**			
☐	**Sister 3**			
☐	**Sister 4**			
☐	**Son 1**			
☐	**Son 2**			
☐	**Son 3**			
☐	**Son 4**			
☐	**Daughter 1**			
☐	**Daughter 2**			
☐	**Daughter 3**			
☐	**Daughter 4**			

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5. SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated	Use seat belt: ☐ Yes ☐ No
Working Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Not Working	Use sunscreen: ☐ Yes ☐ No
How many cigarettes do you smoke each day? ☐ Pipes? ☐ Cigars?	Fire alarm at residence: ☐ Yes ☐ No
Number of years smoking:	Have you ever used narcotics or other addictive drugs? ☐ Yes ☐ No
Year quit smoking:	Do you consider your diet adequate? ☐ Yes ☐ No
How much beer do you drink each day? ☐ Hard Liquor? ☐ Wine?	Do you feel you receive adequate sleep? ☐ Yes ☐ No
Did you ever drink more than you do now?	Are you regularly exposed to any chemicals, toxins, poisons, fumes, smoke, or radioactive material at home or work? ☐ Yes ☐ No
Year quit drinking:	Do you regularly participate in any strenuous physical activity or exercise program? ☐ Yes ☐ No

6. ALLERGIES

Have you ever had an allergic reaction to any medication? ☐ Yes ☐ No
If yes, list medications and reaction:

MEDICATION	REACTION	WHEN?

List any Non-Medication allergies:

NON-MEDICATIONS	REACTION	WHEN?

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7. MEDICATIONS

List all drugs or medications you use regularly
(Include birth control pills and non-prescription items – laxatives, pain pills, cold tablets, etc.)

Medication Name	Dose	Times Daily	Reason	Medication Nam	Dose	Times Daily	Reason

8. IMMUNIZATIONS

IMMUNIZATIONS		YEAR
Influenza	☐ Yes ☐ No	
Pneumonia	☐ Yes ☐ No	
Tetanus	☐ Yes ☐ No	
Hepatitis B	☐ Yes ☐ No	

9. ADVANCED DIRECTIVES

Do you have an advance directive/living will? ☐ Yes ☐ No

If you have an advance directive/living will, will you provide this office a copy for your medical record? ☐ Yes ☐ No

If you would like information regarding advance directives please ask the nurse of your doctor.

10. HEALTH MAINTENANCE REVIEW

	Date of Last		Date of Last
Physical Exam		Stool Blood	
Breast/GYN Exam		Prostate Exam	
Mammogram		Blood Transfusi	
Cholesterol Test		TB Test	

NURSING COMMENTS/REVIEW OF IMMUNIZATIONS:

HAVE YOU COMPLETED ALL SECTIONS AND ANSWERED ALL QUESTIONS?

Please list any additional problems or special concerns about your health which you would like to discuss with your doctor:

Would you like more information about:

- ☐ Family Planning or Birth Control
- ☐ Nutrition or Weight Control
- ☐ Alcohol or Drug Abuse Treatment
- ☐ Smoking Cessation
- ☐ Other: