NHS Adult Health Questionnaire

Patient Name: _____**Date**: _____**Patient ID:** _____

Birth Date:_____ **Gender:** (Circle: Male/Female/Transgender) **Marital Status:** (Circle: Single, Married, Partnered)

Currently Employed? (Yes/No) **If Yes, Occupation:**_____ **Children:** (Yes/No)

Please list all hospitalizations, surgery, and serious illness or injury:

Year	Describe Problem, Surgery, Hospitalization, or Injury

Please list estimation/approximate year of any immunizations (shots):
Tetanus_____ Hepatitis A_____ Hepatitis B_____ HPV (Gardasil)_____Pneumococcal_____
Measles/Mumps/Rubella_____ Other (describe)_____

Medical History-Please check any of the following which you have ever had:

___Abnormal pap smear/colposcopy/LEEP
___Abnormal mammogram
___Alcoholism or Chemical Dependency
___Allergies (Describe:_____)
___Anemia
___Arthritis
___Asthma
___Bladder or kidney disorder
___Bleeding problems (clots, bruising, transfusion)
___Bronchitis (frequent)
___Colitis/colon polyps
___Cancer (Type:_____)
___Chicken Pox/Shingles
___DES Exposure
___Diabetes
___Eating Disorder
___Eczema
___Emphysema/chronic lung disease
___Gallbladder disease
___Glaucoma
___Hayfever/allergies/sinus problems
___Headaches (frequent/migraine)
___High Cholesterol
___Heart disease (Type:_____)
___Hepatitis/jaundice/liver disease
___High blood pressure
___Malaria/parasites
___Mental Illness/Depression
___Pneumonia
___Polio
___Rheumatic fever
___Seizures
___Stroke
___Thyroid Disease
___Tuberculosis/Lung Infection
___Ulcers

Adult Preventative Screening Tests: When were your last tests/examinations? (Leave blank if never)
Bone Density: _____ Colonoscopy: _____ Stool Blood Test: _____
Mammogram:_____ Eye Exam:_____ Dental Exam:_____

Female Only-Please complete the following (Leave blank if never):
Age at first period: ____ Date of last period: _____Age at first child: ____Date of last Pap smear:_____

Please complete or circle the following information:
Who do you currently live with?_____
Do you smoke/use tobacco? (Yes/No) If Yes, how much per day?_____ Interested in quitting? (Yes/No)
Are you exposed to or around people who smoke? (Yes/No)
Do you eat fruits and vegetables each day? (Yes/No) In a typical week, how often do you exercise? _____
In a typical week, how many alcoholic drinks do you have?_____
Do you use recreational/street drugs? (Yes/No) If yes, how often per week?_____
Do you wear a seatbelt? (Always/Sometimes/Never) Do you have a working smoking detector in the home? (Yes/No)
Do you have any piercings or tattoos? (Yes/No)

Family History

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's	Mom's Dad	Dad's Mom	Dad's Dad	Comments
Alcoholism/Chemical Dependency									
Cancer-what kind? (Breast/Colon or Rectum/Lung/Prostate)									
Diabetes									
Heart Disease-what kind?									
High blood pressure									
High cholesterol									
Kidney problems									
Mental illness-what kind?									
Stroke									
Thyroid disease									
Other									

Sexual Health and Family Planning-Please complete the following information:
Are you currently sexually active? (Yes/No) If yes, how many partners have you had in the past year? _____
Are your partners: Male/Female/Transgender (circle all that apply):
Do you or your partner wish to become pregnant? (Yes/No) If Yes, when? _____
Current birth control (or contraception) method, if any: _____
Previous/past birth control (or contraception) method, if any:_____
What are you and/or your partner using to protect against sexually transmitted infections?_____
Are you or have you been sexually/physically abused? (Yes/No) If yes, do you want to talk about it? (Yes/No)
Check any of the following you currently have, or have had in the past:

- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Genital Warts/HPV
- ☐ Syphilis
- ☐ Trichomonas
- ☐ HIV
- ☐ Genital Herpes
- ☐ Hepatitis B
- ☐ Pelvic Inflammatory Disease
- ☐ Other, please list: _____

Is there anything else you would like us to know about you? Do you have any questions or concerns?
_____
_____

To the best of my knowledge, this information is complete and correct:

_____ _____
Patient Signature Date

FOR CLINIC STAFF ONLY- PLEASE SEND TO SCANNING FOR EMR ENTRY

☐ I have reviewed this information with the patient:

_____ _____
Provider Signature Date