

SANTE CARE CENTER

ADULT HEALTH QUESTIONNAIRE

This questionnaire will help your physician obtain a large amount of information while still being able to focus on your important problems. Please answer all questions as best you can. If you are unsure about a question, we will be happy to help you. All questions will be kept confidential.

Name (<i>Last, First, M.I.</i>):		☐ M ☐ F	DOB:
Race:	☐ Caucasian, ☐ Asian, ☐	Ethnicity: (<i>i.e. German, Italian</i>):	
Home Phone: ()	Cell Phone: ()	Work Phone: ()	

CURRENT MEDICATIONS (*Please include all medications - prescribed, over-the-counter, vitamins, etc.*)

☐ NONE - Taking NO Medications

MEDICATION NAME	DOSE (mg)	How many times per	Do you have any side-effects? If yes, please describe them

MEDICATION ALLERGIES (*List all medications you cannot take or have a reaction to.*)

☐ NONE - NO ALLERGIES TO MEDICINES

MEDICATION NAME	What is your reaction to this medication?

SANTE CARE CENTER
ADULT HEALTH QUESTIONNAIRE

MEDICAL HISTORY -- PLEASE CHECK ALL THAT APPLY														
Amputation	☐	Yes	☐	No	Depression	☐	Yes	☐	No	Kidney Disease	☐	Yes	☐	No
Anemia	☐	Yes	☐	No	Diabetes Mellitus	☐	Yes	☐	No	Muscles Weakness	☐	Yes	☐	No
Angina	☐	Yes	☐	No	Emphysema	☐	Yes	☐	No	Nerve/Muscle Disease	☐	Yes	☐	No
Anxiety	☐	Yes	☐	No	Eye Disease	☐	Yes	☐	No	Obesity	☐	Yes	☐	No
Arterial Disease	☐	Yes	☐	No	Falls	☐	Yes	☐	No	Osteoporosis	☐	Yes	☐	No
Arthritis	☐	Yes	☐	No	Fractures	☐	Yes	☐	No	Poor Circulation	☐	Yes	☐	No
Asthma	☐	Yes	☐	No	Gangrene	☐	Yes	☐	No	Seizures	☐	Yes	☐	No
Bladder Problems	☐	Yes	☐	No	Glaucoma	☐	Yes	☐	No	Sickle Cell Anemia	☐	Yes	☐	No
Bleeding Problems	☐	Yes	☐	No	Hand or Feet numbness/tingling	☐	Yes	☐	No	Stroke	☐	Yes	☐	No
Bowel Problems	☐	Yes	☐	No	Heart Attack	☐	Yes	☐	No	Substance Abuse	☐	Yes	☐	No
Cancer	☐	Yes	☐	No	Heart Failure	☐	Yes	☐	No	Thyroid Disease	☐	Yes	☐	No
Cataracts	☐	Yes	☐	No	Heart Murmur	☐	Yes	☐	No	Ulcers	☐	Yes	☐	No
Chest Pain	☐	Yes	☐	No	High Cholesterol	☐	Yes	☐	No	Weight Loss	☐	Yes	☐	No
Cirrhosis	☐	Yes	☐	No	HIV/AIDS	☐	Yes	☐	No					
COPD	☐	Yes	☐	No	Hypertension	☐	Yes	☐	No					

Medical History:

SCREENINGS/IMMUNIZATIONS -- PLEASE CHECK ALL THAT APPLY			
Last tetanus shot	Date: _____	Pneumonia vaccine	Date: _____
Last flu shot	Date: _____	Hepatitis B Series	Date: _____
Last mammogram	Date: _____	Last colonoscopy	Date: _____

SURGICAL HISTORY -- PLEASE CHECK ALL THAT APPLY														
Abdomen surgery	☐	Yes	☐	No	Gastrostomy	☐	Yes	☐	No	Joint replacement	☐	Yes	☐	No
date:					date:					date:				
Appendectomy	☐	Yes	☐	No	Cosmetic surgery	☐	Yes	☐	No	Lung cancer surgery	☐	Yes	☐	No
date:					date:					date:				
Back surgery	☐	Yes	☐	No	Colon surgery	☐	Yes	☐	No	Prostate surgery	☐	Yes	☐	No
date:					date:					date:				
Brain surgery	☐	Yes	☐	No	Eye surgery	☐	Yes	☐	No	Small intestine surgery	☐	Yes	☐	No
date:					date:					date:				
Breast surgery	☐	Yes	☐	No	Fracture surgery	☐	Yes	☐	No	Valve replacement	☐	Yes	☐	No
date:					date:					date:				
CABG	☐	Yes	☐	No	Gastric Bypass	☐	Yes	☐	No	Amputation	☐	Yes	☐	No
date:					date:					date:				
Colostomy	☐	Yes	☐	No										
date:														

Other Surgical History:

SANTE CARE CENTER
ADULT HEALTH QUESTIONNAIRE

Family History: please list any conditions that run in your family

DEPRESSION SCREENING

☐ Yes

☐ No

Over the past 2 weeks, have you felt down, depressed or hopeless?

☐ Yes

☐ No

Over the past 2 weeks, have you felt little interest or pleasure in doing things?

SOCIAL SUPPORT

Do you receive or need regular health care from any other source:

	USE	NEED
Medical Equipment or Diabetes Supplies	☐	☐
Optometrist	☐	☐
Podiatry	☐	☐

EMERGENCY CONTACT

Who would be able to help you in case of an emergency?

Name:

Phone Number(s): cell ()

home ()