Date:

CABOT MEDICAL CARE HEALTH HISTORY- ADULT

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

HEALTH HABITS AND PERSONAL SAFETY						
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
General Health	In general would you say your health is: Excellent, Very Good, Good , Fair or Poor					
	In general would you say your dental health is: Excellent, Very Good, Good , Fair or Poor					
	Please select your current pain level (0-No pain-10 in severe pain) 0 1 2 3 4 5 6 7 8 9 10					
10ADL	Do you require help with any of the following activities? (please circle all that apply) Bathing, Dressing, Toilet Use, Transferring, Urine/Bowel Incontinence, Eating, Shopping, Housekeeping, Handling Finances, Taking Medications					
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you wear your seatbelt?				☐ Yes	☐ No
	Do you have throw rugs in your home?				☐ Yes	☐ No
	Does your home have poor lighting?				☐ Yes	☐ No
	Do you have a slip resistant mat in Bathtub and/or shower?				☐ Yes	☐ No
	Do you have grab bars in your bathroom?				☐ Yes	☐ No
	Do you have functioning smoke alarms in your home?				☐ Yes	☐ No
	Do you have handrails on stairs and steps at your home?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

Please turn to next page

Please turn to next page

Name *(Last, First, M.I.):*	**DOB:**

Allergies to medications	
Name the Drug	Reaction You Had

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

List any medical problems that other doctors have diagnosed				
Do you currently have?				
Pacemaker ☐ Yes ☐ No	Defibrillator ☐ Yes ☐ No	Pain Stimulator ☐ Yes ☐ No	Pain Pump ☐ Yes ☐ No	Allergy to IV Contrast ☐ Yes ☐ No
Have you ever had a blood transfusion?			☐ Yes	☐ No
Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio				

Other hospitalizations		
Year	Reason	Hospital

Please turn to next page

Name *(Last, First, M.I.):*	**DOB:**

		Date/Year		Date/Year
Immunizations and dates:	☐ Tetanus		☐ Pneumonia	
	☐ Hepatitis		☐ Chickenpox	
	☐ Influenza		☐ MMR *Measles, Mumps, Rubella*	
	☐ Shingles		☐ Other:	

	Date/Year		Date/Year		Date/Year
Preventative Screenings and dates:	☐ Aortic Ultrasound		☐ Dilated Eye Exam/Eye Exam		☐ Other:	
	☐ Bone Density Test		☐ Mammogram			
	☐ Colonoscopy		☐ Pap			
	☐ Dental Exam		☐ Prostate Screening (PSA)			

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you fell anxious often?	☐ Yes	☐ No
Are you unable to control or stop worrying?	☐ Yes	☐ No
Do you often feel stress about your health, finances, family, relationships or work?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you get the social and emotional support you need?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

List any other doctors who follow your care and why they see you:

Do you have an Advance Directive or Living Will?	☐	Yes	☐	No
Would you like information on the preparation of these?	☐	Yes	☐	No

Name *(Last, First, M.I.):*	**DOB:**

Please turn to next page

Surgeries		
Year	Reason	Hospital

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	Have you ever felt you should cut down on how much you drink?			☐ Yes	☐ No
	Have people annoyed you by criticizing your drinking?			☐ Yes	☐ No
	Have you ever felt bad about your drinking?			☐ Yes	☐ No
	Have you ever had a drink first thing in the morning to steady your nerves or to get			☐ Yes	☐ No
	rid of a hangover (eye-opener)?				
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No

Name *(Last, First, M.I.):*	**DOB:**

Please turn to next page

WOMEN ONLY				
Age at onset of menstruation:				
Date of last menstruation:				
Period every _____ days				
Heavy periods, irregularity, spotting, pain, or discharge?	☐	Yes	☐	No
Number of pregnancies _____ Number of live births _____				
Are you pregnant or breastfeeding?				
Have you had a D&C, hysterectomy, or Cesarean?	☐	Yes	☐	No
Any urinary tract, bladder, or kidney infections within the last year?	☐	Yes	☐	No
Any blood in your urine?	☐	Yes	☐	No
Any problems with control of urination?	☐	Yes	☐	No
Any hot flashes or sweating at night?	☐	Yes	☐	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐	Yes	☐	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐	Yes	☐	No
Date of last pap and rectal exam?	☐	Yes	☐	No
Date of last Mammogram?				

MEN ONLY				
Do you usually get up to urinate during the night?	☐	Yes	☐	No
If yes, # of times_____	☐	Yes	☐	No
Do you feel pain or burning with urination?	☐	Yes	☐	No
Any blood in your urine?	☐	Yes	☐	No
Do you feel burning discharge from penis?	☐	Yes	☐	No
Has the force of your urination decreased?	☐	Yes	☐	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐	Yes	☐	No
Do you have any problems emptying your bladder completely?	☐	Yes	☐	No
Any difficulty with erection or ejaculation?	☐	Yes	☐	No
Any testicle pain or swelling?	☐	Yes	☐	No
Date of last prostate and rectal exam?	☐	Yes	☐	No
OTHER PROBLEMS	☐	Yes	☐	No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No

Name *(Last, First, M.I.):*	**DOB:**

Please turn to next page

CHECK IF YOU HAVE, OR HAVE HAD, ANY SYMPTOMS IN THE FOLLOWING AREAS TO A SIGNIFICANT DEGREE AND

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

LAB	
LAST LAB (APPROXIMATE DATE):	ORDERED BY (WHOM):
WHAT LAB WAS DONE?	