Apple Valley
FAMILY MEDICINE

1008 S. 38th Ave., Suite 110 ▪ Yakima, WA 98902
V: 509-965-1035 ▪ F: 509-225-2700
MEMORIAL Physicians PLLC

Adult
Health Questionnaire

Please provide information which will help construct a complete health record and plan.

Name _____ Age_____ Birth date_____

What medications are you taking regular?

Name	Dose

Are you allergic to any medications or foods? Please list:

List any surgeries (appendix, gallbladder, hysterectomy, etc.):

Name	Date	Hospital

List any major illnesses (diabetes, high blood pressure, heart trouble, chronic lung problems, cancer):

Name	Date Diagnosed

List serious injuries:	**Date**

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VACCINATIONS

Have you completed all of the usual childhood immunizations (diphtheria, tetanus, whooping cough, oral polio, measles, mumps, and rubella? _____

When was your last tetanus booster? _____

Do you take a yearly influenza ("flu") shot? _____

Have you ever had Pneumovax ("pneumonia shot")? _____

If you work in a health care facility or institution for the retarded have you received Hepatitis B vaccination? _____

Date of pregnancies and deliveries: _____

FAMILY MEDICAL HISTORY

Name	Age	Deceased	Illness?
Mother			
Father			
Brother(s)			
Sister(s)			
Children			

List any family members with cancer:

Relationship	Type of Cancer

PERSONAL HISTORY

Where were you born? _____ How many years in school? _____

Present marital status: _____

Occupation: _____ Spouse's occupation: _____

Religious preference: _____ Hobbies or interests: _____

HEALTH HABITS

How much do you smoke? _____ Packs/day _____ None

How much alcohol do you drink? _____ How much do you exercise? _____

How often do you use a seatbelt? _____

Do you have any financial or stressful family problems which may be affecting your health?

_____

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Are you having any of the following problems? (please check)

_____ Visual problems _____ Blood in stool _____ Decreased hearing

_____ Difficulty passing urine _____ Lump in breast _____ Sore that doesn't heal

_____Unexplained sweats _____ Recent unexplained weight loss

FAMILY

Mother's occupation _____Father's occupation_____

Who does the child live with? _____

Who cares for the child during the day? _____

Who lives in your home? _____

Is there any known family history of inherited diseases? (hemophilia, sickle cell disease, deafness,

Juvenile diabetes, etc.) _____

_____

Have there been any changes in the home which may be affecting your child? _____

_____

SCHOOL

Please comment on your child's school progress:

Academic: _____

Social: _____

Athletic: _____

Are there any sexual development issues which you would like discussed with your child?

_____

Additional comments: _____

_____

_____

_____

_____ _____ _____

Signature Relationship Date