Rush-Copley Medical Group

Patient Health Questionnaire

Adult Medical History Form

Name: _____ Birthdate: _____ Today's Date: _____
Please list your Medication **Allergies**: _____
_____
Please list your current prescription **medicine**, over-the-counter medications, vitamins, supplements, and herbal products you take regularly (you may use the back of page 3 if needed)

Medication/Supplement Name	Dose	How often	Reason for Medication/ supplement

Health History – Please check if appropriate and indicate how many years present

	Years present	**Condition**
☐	_____	Arthritis _____
☐	_____	Asthma _____
☐	_____	Cancer (type: _____)
☐	_____	Diabetes _____
☐	_____	Emphysema/COPD _____
☐	_____	Gastrointestinal Problems _____
☐	_____	Heart problems (type: _____)
☐	_____	Kidney problems _____
☐	_____	Liver problems or hepatitis _____
☐	_____	Mental health problems _____
☐	_____	Migraines _____
☐	_____	Osteoporosis (weak bones) Fracture of hip or spine? ☐ yes ☐no
☐	_____	Sexually Transmitted Disease _____
☐	_____	Thyroid problems _____
☐	_____	Other: _____

Place StickerHere

Hospitalizations (include C-sections)

Year	Operation or Illness	Hospital	Doctor

Women's Health

No. of pregnancies ____ No. of miscarriages/abortions ____/____ No. of living children _____
Age you periods began _____ Date of last period _____ How often do periods occur _____
Are you sexually active? ____ Method of pregnancy prevention_____
Date of last mammogram (age 40+): _____ Results: □ Normal □ Other: _____
Date of last PAP smear: _____ Results: □ Normal □ Other: _____

Family History if Illness (please list close relative and age of diagnosis or death if known)

Asthma: _____
Cancer: _____
Diabetes: _____
Heart Disease: _____
High Blood Pressure: _____
Mental Health: _____
Other: _____
Family Deaths at an early age (under 60): _____

Social History

Marital status: _____ Education (highest level): _____ Occupation: _____
How many children do you have? _____ How many brothers/sisters? _____ / _____
Do you smoke? □ yes □ no □ former ____ packs per day ____ years smoked ____ years quit
Do you chew tobacco? □ yes □ no □ former Do you have any toxic work exposures: † no † yes
Do you drink alcohol? □ yes □ no □ former ___ average drinks per week ___Max. drinks a day
Do you use marijuana, cocaine or similar drugs?: □ yes □ no □ former
Have you traveled outside of the U.S. in the last 6 months:† no † yes: _____
How would you describe your diet? _____ How often do you exercise? _____ days per week

Prevention (please answer the questions to the best of your ability):

Date of last flu shot _____ Date of Shingles shot (over 60) _____
Date of last pneumonia shot _____ Dates of HPV shots (women 9-26+) _____
Date of last tetanus shot _____ Dates of Hepatitis B shots: _____
Have you ever had Chickenpox or the chickenpox vaccine? □ yes □ no □ unsure
Date of last cholesterol check _____ Results: □Normal □ Borderline □ High □ Unknown
Date of last colon cancer screening (age 50+): _____ Type of screening: _____
Date of last glaucoma screen (age 65+, 50+ for African American): _____
Do you have a living will or power of attorney for healthcare? □ yes □ no
Would you like information on living wills or power of attorney? □ yes □ no
Name of person completing this form: _____

Reviewed by healthcare provider (Initials and date): _____ ____ /____ / _____