EvergreenHealth

Adult Health Questionnaire

Name:____ **Date of Birth**__________________________

Medication List (includes nutritional/herbal supplements)

Medication	Dose (strength)	How often?	Reason taken

Medication Allergies/ Reactions/ intolerances

Medication	Reaction

Past Surgery/Procedures

Past Surgery/Procedures	Date

Immunizations

	No	Yes	Date
Standard childhood vaccines	☐ No	☐ Yes	____________
HPV vaccine	☐ No	☐ Yes	____________
Last Tetanus	☐ No	☐ Yes	____________
Tdap (whooping cough vaccine)	☐ No	☐ Yes	____________
Pneumonia vaccine	☐ No	☐ Yes	____________
Hepatitis A vaccine	☐ No	☐ Yes	____________
Hepatitis B vaccine	☐ No	☐ Yes	____________
Shingles Vaccine	☐ No	☐ Yes	____________
Influenza	☐ No	☐ Yes	____________

*MA note: please update all immunizations on "immunization tab"

Past Exams (Preventative health maintenance)

	No	Yes	Date
Diabetes Screening			
Glucose	☐ No	☐ Yes	____________
HgbA1C	☐ No	☐ Yes	____________
Cholesterol Screening	☐ No	☐ Yes	____________
Pap Smear	☐ No	☐ Yes	____________
Breast Cancer Screening			
Mammogram	☐ No	☐ Yes	____________
Breast Ultrasound	☐ No	☐ Yes	____________
Breast MRI	☐ No	☐ Yes	____________
Prostate Cancer Screening	☐ No	☐ Yes	____________
Colorectal Screening			
Stool blood test	☐ No	☐ Yes	____________
Sigmoidoscopy	☐ No	☐ Yes	____________
Colonoscopy	☐ No	☐ Yes	____________
Bone Density Test	☐ No	☐ Yes	____________

Family History: unknown________ adopted_______ unable to obtain______(Mark "+" if present)

Disease	Mother	Father	Sister	Brother	Other/comments
Breast cancer					
Colon cancer					
Prostate cancer					
Diabetes					
High Blood Pressure					
High Cholesterol					
Heart attack					
Strokes					
Depression					
Bipolar					
Alcohol or Drug Abuse					

Other (write in) ____

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