**ADULT HEALTH DATABASE** **NAME:** _____ **DOB:** _____
**DATE:** _____

**Have you been seen by another Doctor since your last Physical?** ☐ **NO** ☐ **YES** **Please list all:** _____
_____

**A. Since your last health maintenance exam, have you:**

1. been hospitalized? ☐ No ☐ Yes _____
2. had surgery? ☐ No ☐ Yes _____
3. had an allergic reaction? ☐ No ☐ Yes _____
4. had a major illness/accident? ☐ No ☐ Yes _____
5. had a transfusion? ☐ No ☐ Yes _____

**Do you:** 1. smoke? ☐ No ☐ Yes -how much? _____
2. follow a special diet? ☐ No ☐ Yes
3. drink alcohol? ☐ No ☐ Yes -how much? _____ how often? _____
4. use other drugs? ☐ No ☐ Yes _____
5. have guns in your home? ☐ No ☐ Yes

**Do you:** 1. wear seatbelts? ☐ No ☐ Yes
2. wear a bike helmet? ☐ No ☐ Yes
3. use sunscreen? ☐ No ☐ Yes
4. have a living will? ☐ No ☐ Yes

**Any abuse or violence in your life?** ☐ No ☐ Yes
**Any major changes in your family/personal life?** ☐ No ☐ Yes
**Do you have a family history of drug/alcohol abuse?** ☐ No ☐ Yes
**Are you an organ donor?** ☐ No ☐ Yes

***FOR WOMEN ONLY:***

| | | |
|---|---|---|
| *Have you:* | *had sexual activity before age 16?* | ☐ *Yes* ☐ *No* |
| | *had more than 5 sexual partners in your life?* | ☐ *Yes* ☐ *No* |
| | *ever had a sexually transmitted disease?* | ☐ *Yes* ☐ *No* |
| | *ever had an abnormal pap?* | ☐ *Yes* ☐ *No* |

**Current occupation:** _____ **How Long?** _____

**A. Do you have any concerns today?** _____
**PLEASE ANSWER ALL QUESTIONS BELOW:**

**HEAD & NECK:**
☐ Y ☐ N Headaches
☐ Y ☐ N Breast Lump
☐ Y ☐ N Lumps or swelling

☐ Y ☐ N Double vision
☐ Y ☐ N Decline in vision
☐ Y ☐ N Eyes water or itch

**EARS:**
☐ Y ☐ N Earache
☐ Y ☐ N Drainage
☐ Y ☐ N Noise in ears ☐
☐ Y ☐ N Trouble hearing

**MOUTH:**
☐ Y ☐ N Taste changes
☐ Y ☐ N Soreness
☐ Y ☐ N Dental problems

**NOSE/THROAT:**
☐ Y ☐ N Bleeding
☐ Y ☐ N Frequent cold/sore throats

**CIRCULATION:**
☐ Y ☐ N Chest Pains
☐ Y ☐ N Chest tightness
☐ Y ☐ N Racing heart/palpitations
☐ Y ☐ N Leg cramps
☐ Y ☐ N Ankles/feet swelling
☐ Y ☐ N High blood pressure

**DIGESTIVE:**
☐ Y ☐ N Nausea

☐ Y ☐ N Gas
☐ Y ☐ N Heartburn/indigestion
☐ Y ☐ N Hard to swallow
☐ Y ☐ N Vomited blood
☐ Y ☐ N Loose bowels
☐ Y ☐ N Diarrhea
☐ Y ☐ N Constipation
☐ Y ☐ N Pain with stools
☐ Y ☐ N Grey or black stools

**SKIN:**
☐ Y ☐ N Dry-itchy
☐ Y ☐ N Rashes
☐ Y ☐ N Bruises easily

**MUSCLE/BONES:**
☐ Y ☐ N Back pain
☐ Y ☐ N Joint pain/stiffness
☐ Y ☐ N Muscle aches

**CONTRACEPTION:**
☐ None ☐ Pill ☐ IUD

☐ Condom ☐ Diaphragm
☐ Norplant ☐ Depo-Provera

**GENERAL:**
☐ Y ☐ N Fever

Sexual Attraction: ☐ Male ☐ Female

**LUNGS:**
☐ Y ☐ N Numbness
☐ Y ☐ N Wheezing
☐ Y ☐ N Frequent dizziness
☐ Y ☐ N Coughing

**NEUROLOGICAL:**
☐ Y ☐ N Fainting
☐ Y ☐ N Coughing up blood
☐ Y ☐ N Convulsions
☐ Y ☐ N Shortness of breath
☐ Y ☐ N Falling/Unsteady Gait
☐ Y ☐ N Memory changes

**GENITOURINARY:**
☐ Y ☐ N Pain with urination
☐ Y ☐ N Frequent urination-day
☐ Y ☐ N Frequent urination-pm
Y ☐ N Hard to stop urine
☐ Y ☐ N Lack of control
☐ Y ☐ N Brown/Bloody urine
☐ Y ☐ N Problems with sex

**FEMALES ONLY:**
☐ Y ☐ N Menstrual pain
☐ Y ☐ N Irregular periods
☐ Y ☐ N Heavy periods
☐ Y ☐ N Vaginal discharge

**MALES ONLY:**
☐ Y ☐ N Weak or slow urine flow
☐ Y ☐ N Prostate trouble
☐ Y ☐ N Lumps in testicles
☐ Y ☐ N Penile discharge

.....over

**ACTION PLAN:**
**Do you:** Exercise? ☐ No ☐ Yes -what type? _____ how often? _____

***Goals to change your health**

What will you do? _____

How much will you do? _____

How often will you do it? _____

Things that might make it hard? _____

**PHQ-2: In the past two weeks have you:**
☐ Y ☐ N Had little interest or pleasure in doing things
☐ Y ☐ N Felt down, depressed or hopeless

****** PROCEED ONLY IF YOU ANSWERED YES TO EITHER OF ABOVE PHQ-2 QUESTIONS**

**PHQ-9:**
**Over the last 2 weeks, how often have you been bothered by any of the following problems?**
Choose an answer of Not at all, Several days, More than half the days, or Nearly every day.

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | ☐ | ☐ | ☐ | ☐ |
| 2. Feeling down, depressed, or hopeless | ☐ | ☐ | ☐ | ☐ |
| 3. Trouble falling or staying asleep, or sleeping too much | ☐ | ☐ | ☐ | ☐ |
| 4. Feeling tired or having little energy | ☐ | ☐ | ☐ | ☐ |
| 5. Poor appetite or overeating | ☐ | ☐ | ☐ | ☐ |
| 6. Feeling bad about yourself--or that you are a failure or have let yourself or your family down | ☐ | ☐ | ☐ | ☐ |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | ☐ | ☐ | ☐ | ☐ |
| 8. Moving or speaking so slowly that other people could have noticed.<br>Or the opposite --<br>Being so fidgety or restless that you have been moving around a lot more than usual | ☐ | ☐ | ☐ | ☐ |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way | ☐ | ☐ | ☐ | ☐ |

(Healthcare professional: For interpretation of TOTAL, Please refer to accompanying scoring card.) **TOTAL:** _____

| | Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|---|
| 10. If you choose any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | ☐ | ☐ | ☐ | ☐ |

When did the symptoms begin? _____