DRAVES FAMILY MEDICINE

1471 U.S. Hwy 61
Festus, MO 63028

Telephone (636) 937-2700

ADULT HEALTH HISTORY QUESTIONNAIRE
(over 13 years of age)

Name:______________________________ Date: ______________

ARE YOU BOTHERED BY . . . IN THE PAST OR PRESENT?

	YES	NO		YES	NO		YES	NO
Skin Problems	____	____	Wheezing	____	____	Constipation	____	____
Headaches	____	____	Chest Pain	____	____	Blood in Stools	____	____
Visual Problems	____	____	Swelling of Legs/Feet	____	____	Tarry Stools	____	____
Sinus Problems	____	____	Abdominal Pain	____	____	Burning w/Urination	____	____
Hearing Loss/Pain	____	____	Heartburn/Indigestion	____	____	Joint/Bone Pain	____	____
Cough	____	____	Nausea/Vomiting	____	____	Seizures	____	____
Shortness of Breath	____	____	Diarrhea	____	____	Loss of Consciousness	____	____

MEN	YES	NO	WOMEN	YES	NO
Poor Urine Stream	____	____	Irregular Periods	____	____
Prostate Trouble	____	____	Vaginal Discharge	____	____
Burning/Discharge from Penis	____	____	Lumps in Breast	____	____
Difficult Erection	____	____	Last Pap (Date)	__________	

DO YOU OR ANYONE IN YOUR FAMILY HAVE:

	YES	NO		YES	NO
Diabetes	____	____	History of Tobacco Use	____	____
Breast Cancer	____	____	History of Alcohol Use	____	____
Heart Disease	____	____	History of Drug Use	____	____
Lung Disease	____	____	Date of Last Tetanus	__________	
Kidney Disease	____	____			
Cancer	____	____			

FATHER: ____WELL ____ILL Nature of Illness ______________________________ Age______

____DECEASED Cause of Death ______________________________

MOTHER:____WELL____ILL Nature of Illness ______________________________ Age______

____DECEASED Cause of Death ______________________________

DRUG ALLERGIES: TO WHAT? 1__________ 2 __________ 3__________ 4 __________

SURGERIES: 1__________ 2 __________ 3__________ 4 __________

CURRENT MEDICATIONS: 1__________ 2 __________ 3__________ 4 __________