Reviewed	
Date	By

Hutchinson Clinic
ADULT MEDICAL QUESTIONNAIRE
(over 14 yrs of age)

NAME_____ **AGE**_____

***If uncertain, answer "?" and a nurse or doctor will help you with the answer.

PAST MEDICAL HISTORY – Have you ever had (check yes or no) –

	YES	NO	
Hospitalizations	____	____	_____
Surgery	____	____	_____
Allergy to Medication	____	____	_____
On medication now?	____	____	_____

PERSONAL PROFILE

[ ] Single [ ] Married [ ] Divorced [ ] Widow(er) # of children_____ Occupation_____

Spouse's Name_____ Spouse's Occupation_____

Ages & Names of Children_____

Do/have you: Smoke_____ (packs/day_____ # of years_____) Quit when_____

Drink alcohol_____ (amount/day_____)

FAMILY/PERSONAL HISTORY (Family = brothers, sisters, grandparents, aunts/uncles) – circle Y or N

	YOU	FAMILY			YOU	FAMILY	
Diabetes…….	Y N	Y N	_____	Cancer……	Y N	Y N	_____
Anemia……..	Y N	Y N	_____	Epilepsy…..……..Y	N	Y N	_____
Heart Disease……	Y N	Y N	_____	Glaucoma ……Y	N	Y N	_____
High Blood Pressure…...Y	N	Y N	_____	Inherited Illness.. Y	N	Y N	_____
Kidney Disease……...Y	N	Y N	_____	Tuberculosis…....Y	N	Y N	_____

FATHER: [ ] Healthy [ ] Has medical problem – Explain_____ Age_____

[ ] Dead – Cause of Death_____ Age at Death_____

MOTHER: [ ] Healthy [ ] Has medical problem – Explain_____ Age_____

[ ] Dead – Cause of Death_____ Age at Death_____

NUMBER: Brothers_____ Sisters_____ # Dead_____ Causes of Death_____

SYMPTOM REVIEW – Are you bothered in the past or present by (circle Y or N)

Weight gain/loss……	Y N	Palpitations……	Y N	Is there any disease you are	
Skin problems……...	Y N	Abdominal Pain……	Y N	afraid you might have or get?…	Y N
Headaches…….	Y N	Heartburn/Indigestion…..	Y N	Period problems (females)…….	Y N
Visual problems/eye pain.	Y N	Trouble Swallowing…….	Y N	Vaginal discharge (females).....	Y N
Sinus problems……..	Y N	Decreased appetite……	Y N		
Hay fever……..	Y N	Nausea/Vomiting……..	Y N	"X" IF YOU HAVE HAD –DATE	
Hearing Loss/Ear pain…..	Y N	Diarrhea…….	Y N		
Neck Lumps……..	Y N	Constipation……..	Y N	[ ] Cholesterol Check_____	
Cough……	Y N	Change in bowel habits….	Y N	[ ] Stool blood check _____	
Cough up blood……	Y N	Blood in stools……..	Y N	[ ] Tetanus – last_____	
Shortness of Breath……..	Y N	Tarry or Black stools……	Y N	[ ] Chest x-ray_____	
Sleep w/more than 1 pillow..	Y N	Hemorrhoids…….	Y N	[ ] EKG/Cardiogram_____	
Depression……	Y N	Burning with urination…..	Y N	**Males:	
Crying spells…….	Y N	Blood in urine……	Y N	[ ] Prostate Check_____	
Nervousness…….	Y N	Difficulty urinating……..	Y N	[ ] PSA Blood test_____	
Swelling of Legs/Feet…..	Y N	Joint/Bone Pain…….	Y N	**Females:	
Chest pain/heaviness/		Back Ache/Pain…….	Y N	[ ] Pelvic/PAP_____	
pressure/tightness……..	Y N	Seizure……..	Y N	[ ] Breast Exam_____	
				[ ] Mammogram_____	

Why did you come to the doctor? _____

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