CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Adult Health Review

This questionnaire is intended to identify any new problems and update the status of old ones.
All information provided on this form is confidential.

Name	**Today's Date**
Phone # (home/cell)	**Employer (if working)**

MEDICAL PROBLEMS SINCE YOUR LAST VISIT
Note here any major health concerns, if applicable. Please bear in mind that the focus of a general physical exam (or Medicare Wellness Exam) is on health maintenance and preventative medicine. While new issues may be indentified, their full diagnosis and treatment will likely be deferred to a follow-up visit.

MEDICATION (Prescription and Non-Prescription)
INCLUDING: vitamins, antacids, Tylenol, Ibuprofen (Motrin, Advil) aspirin, any herbal medications or remedies, etc.
Please list those used regularly and dose taken.

MEDICATION ALLERGIES
List any reactions you have had to medications (for example, penicillin or sulfa)

CURRENT HEALTH PRACTICES				
Do you exercise regularly? **YES** **NO** Type of exercise:				
Do you drink alcohol? **YES** **NO** If yes, what kinds? _____ On average, how much per day? _____ Per week? _____				
Do you feel it is important to lose weight at this time? **YES** **NO**				
Circle the word which applies to your seatbelt use: **ALWAYS** **SOMETIMES** **NEVER**				
Have you ever used tobacco products regularly? **YES** **NO** If the answer is **YES**, please fill in the following:				
Tobacco Product	Age Started	Duration of use (years)	Average amount per day	Are you still using? **YES/NO** Year quit:

FAMILY HISTORY

Please **CIRCLE** the problem (if choices) and give age when problem began, if known.

ILLNESS	MOTHER	FATHER	SISTERS	BROTHERS	GRANDPARENTS
Diabetes					
Breast, prostate or colon cancer					
Heart disease or heart attack					
High blood pressure					
Stroke					
Alcoholism					
Osteoporosis (weak bones, hip fracture)					
Depression/Anxiety/Bipolar					
Gall Bladder/Kidney Stones/Stomach Ulcer					
Other					

REVIEW OF SYSTEMS

Please **CIRCLE** the items listed below with which you have had significant problems.

GENERAL		
Recent weight change	Significant fatigue	Always hot/Always cold
Rashes or skin problems	Night sweats/Hot flashes	New or changing skin, moles, or spots

EYE, EAR, NOSE and THROAT		
Brief loss of vision (ever)	Recent hearing change	Recent vision change
Teeth or gum problems	Any other problems with eyes, ears, nose or throat? **YES NO**	

HEART and LUNGS		
Daily cough	Difficulty breathing while laying flat	Ankle swelling
Chest pain	Coughing up blood	Leg cramps while walking
Wheezing	Shortness of breath in day or night	

BREASTS (*WOMEN*)	
Lumps/Any skin changes	Do you do monthly self breast exams? **YES NO**
Drainage from nipple(s)	Month and year of last mammogram:

GASTRONINTESTINAL		
Change of appetite	Diarrhea / Constipation	Difficulty swallowing
Blood in stool / Black stool	Heartburn	Nausea / Vomiting

GENITOURINARY (*BOTH MEN and WOMEN*)		
Difficulty starting urination	Urination more than twice a night	Leaking urine
Blood in urine	Painful urination	Pain or problems with intercourse
Have had or having difficulties with your sex life **YES NO**		

GENITOURINARY (*MEN ONLY*)	
Difficulty getting or keeping an erection **YES NO**	Pain or lump in testicles or scrotum **YES NO**

GENITOURNINARY (*WOMEN ONLY*)		
Change in menstrual pattern **YES NO**	Date of last menstrual period:	Number of children: Boys___ Girls__
Unusual vaginal discharge or itching **YES NO**	Frequency / Length of menstrual periods:	Date of last pelvic exam:
Disabling menstrual cramps **YES NO**		Past history of abnormal periods: **YES NO** If **YES**, date:

NEUROPSYCHIATRIC		
Frequent disabling headaches	Passing out	Frequent anxiety
Difficulty sleeping	Often feel sad or depressed	
Treated in past for emotional or psychological problems		

MUSCULOSKELETAL		
Frequent neck or back pain	Night-time leg cramps or “restless legs”	Muscle or joint problems

SOCIAL		
Recent significant changes in your life	Financial hardships	Dissatisfied with current employment
Special stresses in your life	In an abusive relationship (physical, sexual, verbal)	
Other concerns you wish to discuss:		