MAT-SU MIDWIFERY AND FAMILY HEALTH ADULT MEDICAL QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

First Name: _____Middle Name: _____Last Name: _____

Address:_____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Birth Date: _____/____/____ Age: _____

month day year

Work Phone: (_____) _____-_____

Place of Birth:_____

Occupation: _____ City or town & country if not US

Referred by: _____ Height: ___' ____" Weight: _____ Sex: _____

Today's Date _____

Please check appropriate box(es):

- ☐ African American
- ☐ Native American
- ☐ Hispanic
- ☐ Caucasian
- ☐ Mediterranean
- ☐ Northern European
- ☐ Asian
- ☐ Other

Please list the <u>main concerns, problems, issues or diagnosis</u> you are wanting to address at today's visit.

Main Concerns/problem(s)	Severity of the problem	TREATMENT	SUCCESS/ANY RELIEF?
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate/no relief

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
Example: Wendy, age 7, sister

_____

_____

_____

Do you have any pets or farm animals? Yes/ No

Have you lived or traveled outside of the United States within the past 90 days? Yes/ No
If so, when and where? _____

Have you or your family recently experienced any major life changes? Yes/ No
If yes, please comment: _____

Have you experienced any major losses in life? Yes/ No
If so, please comment: _____

_____

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Do you currently feel safe in your home and with your family?

☐ Yes ☐ No

Would you feel safer discussing any abuse issues or questions privately, with your provider?

☐ Yes ☐ No

Please circle or check next to any Past Medical and Surgical History:

ILLNESSES	When		When
Anemia		Hepatitis	
Arthritis		High blood fats (cholesterol, triglycerides)	
Asthma		High blood pressure (hypertension)	
Bronchitis		Irritable bowel	
Cancer		Kidney stones	
Chronic Fatigue Syndrome		Mononucleosis	
Crohn's Disease or Ulcerative Colitis		Pneumonia	
Diabetes		Rheumatic fever	
Emphysema		Sinusitis	
Epilepsy, convulsions, or seizures		Sleep apnea	
Gallstones		Thyroid issues	
Other(describe)			

INJURIES	When	DIAGNOSTIC STUDIES	When
Back injury		Barium Enema	
Broken (describe)		Bone Scan	
Head injury		CAT Scan of Abdomen	
Neck injury		CAT Scan of Brain	
Other (describe)		CAT Scan of Spine	
		Chest X-ray	
OPERATIONS		Colonoscopy	
Appendectomy		EKG	
Dental Surgery		Liver scan	
Gall Bladder		Neck X-ray	
Hernia repair		NMR/MRI	
Hysterectomy		Sigmoidoscopy	
Tonsillectomy		Upper GI Series	
Other (describe)		Other (describe)	

Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON

What medications are you taking now? Include non-prescription drugs.

Medication Name	Date started	Dosage

Are you allergic to any medications? Yes____ No____

If yes, please list:

_____

List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	Date started	Dosage
Example: Vitamin D	May 2018	2,000 IUs daily

Childhood:

Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
2. Born C-section or vaginal birth?				
3. As a child did you eat a lot of sugar and/or candy?				

Are you on a special diet? Yes/ No

_____ Gluten Free _____ Vegetarian _____ other (describe):
_____ Diabetic _____ Vegan _____
_____ Dairy Free _____ Keto _____

Do you consume caffeine? Yes/ No. If yes, How much?_____

Have you ever used alcohol? Yes____ No____

If yes, how often do you now drink alcohol?

___ No longer drinking alcohol
___ Average 1-3 drinks per week
___ Average 4-6 drinks per week
___ Average 7-10 drinks per week
___ Average >10 drinks per week

Have you ever had a problem with alcohol? Yes/ No

If yes, please indicate time period (month/year): from _____ to _____

Have you, or do you use recreational drugs? Yes/ No
If so, what kind and how often?_____
(Example: Marijuana/CBD oil 3x a week)

Do you or have you ever used tobacco? Yes/ No
If yes, Amount per day _____.
Year quit _____.

What type of nicotine have you used?

_____Cigarette _____ Smokeless
_____Cigar _____Pipe _____Patch/Gum

Are you exposed to second hand smoke regularly? Yes/ No

Have you had any occupational exposures? (i.e. lead, mercury, asbestos) Yes/ No
If so, when and what kind_____

Are you or have you had psychotherapy or counseling? Yes/ No. If yes how long_____

Are you currently, or have you ever been, married? Yes/ No
If so, when were you married? _____Spouse's occupation _____
When were you separated?_____ Never _____
When were you divorced? _____ Never _____
Comments:_____

Do you exercise regularly? Yes/ No

If so, how many times a week?
1._____1x
2._____2x
3._____3x
4._____4x or more

When you exercise, how long is each session?
1._____ ≤15 min
2._____ 16-30 min
3._____ 31-45 min
4._____ > 45 min

What type of exercise is it?

_____Jogging/walking _____Yoga
_____Hiking _____Weight training
_____Winter sports
Other_____

FOR WOMEN ONLY

First day of last menstrual cycle_____
Taking contraceptives? Yes/ No. If so what kind_____
Last Pap_____
Any abnormal paps? Yes/ No
PMS symptoms? _____

Any History of STI's (sexually transmitted infections)? Yes/ No
If yes, When and what type? _____

Have you ever been pregnant? Yes/ No
How many pregnancies? ____ Number of miscarriages____ Number of living children____

Did you have any complications with pregnancy? Yes/ No
If so please describe:
_____
_____

Are you menopausal? Yes/ No.
If yes are you on hormone therapy? Yes/ No
If yes, what kind & when started? _____

FOR MEN ONLY

Do you have a decrease in libido (sex drive)? Yes/ No
Have you decreased strength or loss of exercise tolerance? Yes/ No
Do you have difficulty maintaining an erection? Yes/ No

Do you have testicular pain? Yes/ No
Do you have urinary urgency/change in stream? Yes/ No

Have you had a vasectomy? Yes/ No if yes. When? _____

Any History of STI's (sexually transmitted infections)? Yes/ No

Are there any other symptoms or concerns you would like to address with the provider that was not on this form?

_____
_____
_____
_____

FAMILY MEDICAL HISTORY

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
Alcoholism								
Anemia								
Asthma								
Autism								
Autoimmune Disorder								
Birth Defect/Congenital Anomaly								
Bleeding Problem								
Cancer: Breast								
Cancer: Type_____								
Cancer: Type_____								
Depression								
Developmental Delay								
Diabetes								
Eczema (Atopic Dermatitis)								
Food Allergy								
Genetic Disorder								
Hay Fever (Allergic Rhinitis)								
Hearing Disorder								
Heart Attack/Coronary Artery Disease								
High Cholesterol (Hyperlipidemia)								
High Blood Pressure								
Immune Disorder								
Inflammatory Bowel Disorder (Crohns/UC)								
Kidney Disease								
Migraine Headaches								
Psychiatric/Mental Illness								
Scoliosis								
Stroke								
Substance Abuse								
Thyroid Disorders								
Tobacco Use								
Tuberculosis								
Death before age 56								
Other:								