Valley Community Healthcare

Patient Label:

CHA1

Confidential Adult Health Questionnaire

If you are unsure about any terms, feel free to ask for help.

Name: ______________________________ DOB: ____________ Current Date: ______________

Sex/Gender: ______________________________ Pronouns: __________ Sexual Orientation: ___________

(Use your preferred term, ex.: trans woman, nonbinary, male, N/A, etc.) *(optional, ex.: he, she, they)* *(ex.: lesbian, bi, heterosexual, asexual, etc.)*

Please mark "yes" or "no" if you are currently experiencing or have ever experienced the following conditions, or fill in requested information as appropriate. Write "NA" if not applicable.

CLINIC/HOSPITAL VISIT HISTORY

Have you seen another health care provider in the last year? ◯ No ◯ Yes

Who/Where : ________________________ When: _______ Reason:______________________________

Who/Where : ________________________ When: _______ Reason:______________________________

Have you been hospitalized, visited an ER, or undergone any surgery in the last year? ◯ No ◯ Yes

Where : __________________________ When: _______ Reason:______________________________

Where : __________________________ When: _______ Reason:______________________________

MEDICAL HISTORY

Do you have: (*Please check all that apply)*

◯ High Blood Pressure	◯ Heart Disease	◯ Respiratory Disease	◯ Blood Disease
◯ High Cholesterol	◯ Heart Murmur	◯ Asthma	◯ Anemia
◯ Gallstones	◯ Kidney Disease	◯ Osteoporosis/Bone Problems	◯ Blood Transfusion
◯ Diabetes	◯ Neurological Disease	◯ Stomach or Bowel Disease	◯ Hepatitis
◯ Cancer	◯ Psychiatric Disorders	◯ Urinary Tract Infections	◯ Varicose Veins
◯ Skin Disease	◯ Headaches	◯ Seizures	◯ Rectal Bleeding
◯ Thyroid Problem	◯ Blood Clots *(legs, lungs, other sites [other than menstrual bleeding])*		

◯ Allergies Please list: ____

◯ Are you allergic to any medication? ____

Are you taking any medication regularly: ◯ No ◯ Yes

Please list all medications, including over-the-counter medications (like ibuprofen), vitamins, and supplements:

____

____

Have you had any prior major illnesses or surgeries? ◯ No ◯ Yes

____

____

EXAM & VACCINATION HISTORY

When was your last:	Date:	Or:	When were you last vaccinated for:		
Physical?	______	◯ Don't remember ◯ N/A	Flu?	______	◯ Don't remember ◯ N/A
Cholesterol test? *(If over 35)*	______	◯ Don't remember ◯ N/A	Pneumonia?	______	◯ Don't remember ◯ N/A
Colonoscopy? *(If over 50)*	______	◯ Don't remember ◯ N/A	Tetanus?	______	◯ Don't remember ◯ N/A
DEXA scan? *(If over 65, osteoporosis screening)*	______	◯ Don't remember ◯ N/A		______	◯ Don't remember ◯ N/A

CHA1

SOCIAL HISTORY

Are you currently employed? ◯ No ◯ Yes
Occupation: ______________________________

Are there occupational hazards at your workplace? ◯ No ◯ Yes
(ex., asbestos, chemicals/fumes, excessive noise, etc.)

Do you drink alcohol? ◯ No ◯ Yes — How many drinks? ______ How often? ____________________

Do you smoke cigarettes? ◯ No ◯ Yes — How many (cigarettes / packs) do you smoke per day? _______ *(circle one)*

Do you exercise regularly? ◯ No ◯ Yes — How long? __________ How often? ____________________

Do you take calcium? ◯ No ◯ Yes — How much? _________ How often? ____________________

Do you: ◯ Drink Coffee/Soda/Energy Drinks? How much? ______ How often? ______ ◯ Take caffeine pills/other supplements? How much? ____ How often? ____

Do you use street drugs? ◯ No ◯ Yes — Do you use injection drugs? ◯ No ◯ Yes

Is anyone hurting, threatening, or abusing you? ◯ No ◯ Yes ◯ Decline to state on this form.

Have you ever been physically, emotionally, or sexually abused, or forced to have sex? ◯ No ◯ Yes ◯ Decline

FAMILY HISTORY

Please indicate if on Mother's (M) or Father's (F) side of the family. If adopted (family unknown) check here ◯.

	Side:	Relation:	Date:		Side:	Relation:	Date:
◯ Diabetes	M F			◯ Stroke (before 50)	M F		
◯ Down's syndrome	M F			◯ Stroke (after 50)	M F		
◯ Gallbladder disease	M F			◯ Tay-Sachs disease	M F		
◯ Heart disease	M F			◯ Genetic disease	M F		
◯ Cancer	M F			Type of Cancer: ____________________			

SEXUAL HISTORY

Note: You are not obligated to disclose the gender identity of any of your sexual partners, including your current partner, on this form.

Are you sexually active? ◯ No ◯ Yes Age at first intercourse: _____ Number of sex partners in the last year: ______

Are you sexually active with: *(mark all that apply)* ◯ Women ◯ Men ◯ Partners of Other Genders

Do you currently have a sex partner? ◯ No ◯ Yes If so, how long have you been with them? ________________

Does your current sex partner have: Other sex partners? ◯ No ◯ Yes Male sex partners? ◯ No ◯ Yes

Indicate if any of your current or previous sex partners are: ◯ Injection Drug Users ◯ Sex Workers

CONTRACEPTIVE HISTORY

Current Method: ____

Do you want to change your method? ◯ No ◯ Yes

Check other methods of birth control used in the past. Input approximate dates and any problems you may have had

Select	Type	Date used	Problems, if any	Select	Type	Date used	Problems, if any
◯	Pills (Name)			◯	Condoms		
◯	IUD			◯	Ring/Patch		
◯	Diaphragm			◯	Depo-Provera		
◯	Foam/Film			◯	Rhythm/NAP		

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SEXUALLY TRANSMITTED INFECTIONS HISTORY

Have you had the hepatitis B vaccine? (total 3 injections) ◯ No ◯ Yes, date: ____________________

Have you ever been treated for any of the following STIs?

◯ Chlamydia, date: __________ ◯ Gonorrhea, date: __________ ◯ HIV/AIDS, date: __________
◯ Syphilis, date: __________ ◯ Herpes, date: __________ ◯ Genital warts (HPV), date: __________

Have any of your current or past sex partners been treated for any of the following STIs in the past (or currently)?

◯ Chlamydia, date: __________ ◯ Gonorrhea, date: __________ ◯ HIV/AIDS, date: __________
◯ Syphilis, date: __________ ◯ Herpes, date: __________ ◯ Genital warts (HPV), date: __________

HORMONAL, MENSTRUAL, AND REPRODUCTIVE HEALTH/HISTORY

Are you currently experiencing any pelvic pain? ◯ No ◯ Yes, where/what kind of pain: ____________________
Have you ever had any pelvic surgery? ◯ No ◯ Yes, type of surgery: ____________________
Tubal ligation? ◯No ◯Yes Hysterectomy? ◯No ◯Yes If yes, circle what kind: Total or Partial
Are you currently using birth control pills? (for any reason, such as PMS/PMDD treatment) ◯ No ◯ Yes
Are you currently undergoing Hormone Replacement Therapy (HRT), for any reason? ◯ No ◯ Yes
Have you been exposed to DES (diethylstilbestrol)? (1938-1971) ◯ No ◯ Yes

Mark here if you do not need to fill out the following section: ◯ Note why, if desired: ____________________

Age menstruation began: ______ Date of 1st day of last menstrual period: __________
Usual cycle occurs every _______ days. Usual cycle flows for ________ days.
Usual cramps: ◯ Light ◯ Medium ◯ Heavy Usual flow: ◯ Light ◯ Medium ◯ Heavy
Have you undergone menopause? ◯No ◯Yes, age: _____ Any post-menopausal bleeding? ◯No ◯Yes
Date of last pap smear: ______________ Have you ever had an abnormal pap smear? ______________
Are you able to conceive? ◯ No ◯ Yes Total # of pregnancies (regardless of outcome): ______________
# of each outcome: Live births:_______ Abortions:_______ Cesarean Sections:_______ Miscarriages:_______
If applicable, have you had unprotected sex since your last period? ◯ No ◯ Yes , date: ______________

URINARY/GENITAL HEALTH HISTORY

Have you been experiencing:
Difficulty starting a stream of urine? ◯ No ◯ Yes Blood in your urine? ◯ No ◯ Yes
Getting up at night to urinate? ◯ No ◯ Yes Frequent urination? ◯ No ◯ Yes

Mark here if you do not need to fill out the following section: ◯ Note why, if desired: ____________________

Do you have a history of undescended testicle? ◯ No ◯ Yes ◯ N/A
Do you have a history of impotency? ◯ No ◯ Yes ◯ N/A
Do you have a lump in your testicle? ◯ No ◯ Yes ◯ N/A
Are you experiencing any prostate problems? ◯ No ◯ Yes ◯ N/A (If 50+) Date of last prostate exam:__________

BREAST HEALTH HISTORY

Date of last breast exam: ______________ Date of last mammogram: ______________
Do you have a history of breast problems? ◯ No ◯ Yes, when: ______________
Do you have a family history of breast cancer? ◯ No ◯ Yes, who: ______________
Do you have a history of breast surgery? ◯ No ◯ Yes, when: ______________
What types of breast surgery? ______________

PRESENTING PROBLEM(S)

Indicate below any current symptoms/issues you are experiencing. Sign below when you have finished.

GENERAL HEALTH		
Have you recently experienced:		
Fever:	◯ No	◯ Yes
Chills:	◯ No	◯ Yes
Sweating:	◯ No	◯ Yes
Recent weight change:	◯ No	◯ Yes

SKIN		
Have you recently experienced:		
Acne:	◯ No	◯ Yes
Change in pigment/mole:	◯ No	◯ Yes
History of skin cancer/melanoma:	◯ No	◯ Yes
Rash(es):	◯ No	◯ Yes

VISION		
Have you recently experienced:		
Blurred vision:	◯ No	◯ Yes
Cataract(s):	◯ No	◯ Yes
Glaucoma:	◯ No	◯ Yes
Itchy/watery eyes:	◯ No	◯ Yes

HEMATOLOGY		
Have you recently experienced:		
Anemia:	◯ No	◯ Yes
Easy bruising:	◯ No	◯ Yes
Heavy bleeding:	◯ No	◯ Yes
History of blood transfusion:	◯ No	◯ Yes

EARS, NOSE, THROAT		
Have you recently experienced:		
Bleeding gums:	◯ No	◯ Yes
Ear pain:	◯ No	◯ Yes
Hearing loss:	◯ No	◯ Yes
Hoarseness:	◯ No	◯ Yes
Itchy nose, sneezing:	◯ No	◯ Yes
Nasal discharge, congestion:	◯ No	◯ Yes
Ringing in your ears:	◯ No	◯ Yes

CARDIO-RESPIRATORY		
Have you recently experienced:		
Chest pain:	◯ No	◯ Yes
Chronic cough:	◯ No	◯ Yes
Heart murmur:	◯ No	◯ Yes
High blood pressure:	◯ No	◯ Yes
High cholesterol:	◯ No	◯ Yes
History of heart attack:	◯ No	◯ Yes
Shortness of breath:	◯ No	◯ Yes

GASTRO-INTESTINAL		
Have you recently experienced:		
Abdominal pain:	◯ No	◯ Yes
Black or bloody stool:	◯ No	◯ Yes
Constipation:	◯ No	◯ Yes
Diarrhea:	◯ No	◯ Yes
Gallbladder disease:	◯ No	◯ Yes
Heartburn:	◯ No	◯ Yes
Nausea/vomiting:	◯ No	◯ Yes
Ulcer disease:	◯ No	◯ Yes

ENDOCRINE		
Have you recently experienced or been diagnosed with:		
Diabetes:	◯ No	◯ Yes
Obesity:	◯ No	◯ Yes
Thyroid problem:	◯ No	◯ Yes

MUSCULO-SKELETAL		
Have you recently experienced:		
Back pain:	◯ No	◯ Yes
Joint pain:	◯ No	◯ Yes
Leg cramps:	◯ No	◯ Yes

NEURO/PSYCHIATRIC		
Have you recently experienced or been diagnosed with:		
Depression:	◯ No	◯ Yes
Dizziness:	◯ No	◯ Yes
Headaches:	◯ No	◯ Yes
History of stroke:	◯ No	◯ Yes
Seizure:	◯ No	◯ Yes

GENITO-URINARY		
Have you recently experienced:		
Burning during urination:	◯ No	◯ Yes
Unusual vaginal discharge:	◯ No	◯ Yes
Unusual vaginal bleeding:	◯ No	◯ Yes
Pain during sex:	◯ No	◯ Yes

Do you have any other health concerns? ______________________________

Please sign below:

______________________________ ______________________

Patient’s Signature Date