



The Seattle Arthritis Clinic

ADULT HEALTH QUESTIONNAIRE

Name _____

Date _____

YOUR HEALTH HISTORY: Please mark with an “X” any of the following illnesses and medical problems you have had and indicate the year when each started. If you are not certain when an illness started, write down an approximate year it occurred.

Illness	X	Year	N/A	Illness	X	Year	N/A
Eye or Eyelid infection				Venereal Disease			
Glaucoma				Genital Herpes			
Other Eye Problems				Breast Disease			
Ear Condition				Nipple Drainage			
Deafness or Decreased Hearing				Headaches			
Thyroid Problems				Head Injury			
Step Throat				Stroke			
Bronchitis				Convulsions/Seizures			
Emphysema				Blackouts			
Pneumonia				Dizziness			
Allergies, Astha or Hayfever				Mental Problems			
Nose Bleeds				Arthritis			
Tuberculosis				Gout			
Other Lung Problems				Cancer or Tumors			
Difficulty Breathing				Bleeding Tendency			
High Blood Pressure				Diabetes			
High Cholesterol				Measles/Rubeola			
Arteriosclerosis (hardening of arteries)				German Measles/Rubella			
Heart Attack				Polio			
Chest Pain				Mumps			
Irregular Heart Beat				Scarlet Fever			
Heart Murmur				Chicken Pox			
Other Heart Condition				Mononucleosis			
Stomach/Duodenal Ulcer				Eczema			
Nausea				Psoriasis			
Vomiting				Skin Rash			
Weight Loss				Open Wounds			
Weight Gain				Infection			
Difficulty Swallowing				Muscle Stiffness			
Colitis				Muscle Weakness			
Other Bowel Problems				Bone Fracture			
Blood in Stool				Bone Stiffness			
Diarrhea				Easily Fatigued			
Hemorrhoids				Hepatitis			
Liver Problems				Gallbladder Problems			
Hernia				Kidney or Bladder Disease			
Ovarian Problem				Prostate Problem			
Last Pregnancy				Others			
Menstrual Flow Problems							



The Seattle Arthritis Clinic

NERVOUS SYSTEM

NOW	PAST		NOW	PAST	
_____	_____	Lack of energy	_____	_____	Memory trouble
_____	_____	Frequent loss of balance	_____	_____	Trouble concentrating
_____	_____	Tremor (shaking, trembling)	_____	_____	Depression
_____	_____	Paralysis	_____	_____	Crying spells
_____	_____	Numbness (body parts go to sleep)	_____	_____	Feelings of worthlessness
_____	_____	Nervousness	_____	_____	Trouble getting along with people
_____	_____	Excessive worry	_____	_____	Emotional irritability
_____	_____	Trouble sleeping	_____	_____	Other _____

Smoking: Yes _____ No _____
 If yes, please circle:
 Cigarettes Pipe Cigars

Number of years: _____ Daily Amount: _____

Alcohol: Yes _____ No _____
 If yes, please circle:

Beer Wine Other Weekly Amount: _____

Caffeine: Yes _____ No _____ Daily Amount: _____

Do you use other drugs? Yes ____ No ____
 Hours of sleep per night _____
 Regular exercise? Yes ____ No ____

Current Medical Diagnoses: _____

Physical Therapy:

Other Therapies (i.e., Occupational Therapy, Chiropractic, Massage, Acupuncture, Counseling, etc.):

Surgeries or Hospitalizations:	Reason	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Medications:	Dosage	Frequency
Name		
_____	_____	_____
_____	_____	_____
_____	_____	_____