TORRANCE MEMORIAL PHYSICIAN NETWORK

Adult Health Questionnaire – E-Clipboard/Portal Supplemental Form

Name: _____ Today's Date: _____

Date of Birth:_____ Primary Care Physician:_____

Completed by if other than patient:_____ Relationship:_____

Reason for Visit?_____ How long has this been a problem?_____

Are you in pain? ☐Yes ☐ No

How would you rate your pain on a scale of 0 to 10, with 10 being the most severe pain? _____

If yes, what is the location of the pain? _____

Social History

Marriage:

How is your relationship with your spouse? _____ Is your sex life satisfying? ☐Yes ☐ No

Children:

Number of Children: _____Girls _____ Boys How is your relationship with your children? _____

Occupation: _____ Hours worked per week: _____

Is your work satisfying and free from undue pressure or stresses? ☐Yes ☐ No

Do you miss much time from work? ☐Yes ☐ No

Preferred Pharmacy

Name and Address of Preferred Pharmacy_____

Are you having any problems filling your prescriptions due to their high cost of the medications? ☐Yes ☐ No

Your Specialists

(Please list those you currently see or have seen)

Name	Specialty	Name	Specialty
_____	_____	_____	_____
_____	_____	_____	_____

Immediate Family History:

(Please note the following diseases: Cancer, Diabetes, High Blood Pressure, Heart Trouble, Stroke, Seizures, Thyroid Disorder, Mental Disorders, Asthma, Osteoporosis, Tuberculosis)

Family:	Age (If living)	Deceased: (note age and cause)	Healthy or noted Illness(es):	Additional Siblings with age and condition:
Father:	_____	_____	_____	_____
Mother:	_____	_____	_____	_____
Brother:	_____	_____	_____	_____
Sister:	_____	_____	_____	_____
Son:	_____	_____	_____	_____
Daughter:	_____	_____	_____	_____

Has any blood relative other than immediate family ever had any serious medical conditions:_____

_____