ADULT HEALTH HISTORY FORM

Name: ________________________________ **Date**:_______________ **DOB**:____________________

Occupation: ____________________________ **Highest Grade completed in school:** ____________________

Your answers on this form will help your health care provider better understand your medical concerns and conditions better. This form will not be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. **Thank you!**

Age _______ How would you rate your general health? □ Excellent □ Good □ Fair □ Poor

Main reason for today's visit: ____

Other concerns: ____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional
____ Recent fevers/sweats
____ Unexplained weight loss/gain
____ Unexplained fatigue/weakness

Eyes
____ Change in vision

Ear/Nose/Throat/Mouth
____ Difficulty hearing/ringing in ears
____ Hay fever/allergies/congestion
____ Trouble swallowing

Cardiovascular
____ Chest pains/discomfort
____ Palpitations
____ Short of breath with exertion

Breast
____ Breast lump
____ Nipple discharge

Respiratory
____ Cough/wheeze
____ Coughing up blood

Gastrointestinal
____ Heartburn/reflux
____ Blood or change in bowel movement
____ Nausea/vomiting/diarrhea
____ Pain in abdomen

Genitourinary
____ Painful/bloody urination
____ Leaking urine
____ Nighttime urination
____ Discharge: penis/vagina
____ Unusual vaginal bleeding
____ Concern with sexual functions

Musculoskeletal
____ Muscle/joint pain
____ Recent back pain

Skin
____ Rash
____ New or change in mole

Neurological
____ Headaches
____ Memory loss
____ Fainting

Psychiatric
____ Anxiety/stress
____ Sleep problem

Blood/Lymphatic
____ Unexplained lumps
____ Easy bruising/bleeding

Endo
____ Cold/heat intolerance
____ Increase thirst/appetite

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? □ Yes □ No

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication Dose (e.g., mg/pill) How many times per day

____

____

____

____

____

Allergies or reactions to medications: ____

Have you ever had a latex (rubber) allergy: Yes ______ No ______

Date of your most recent **IMMUNIZATIONS:**
Hepatitis A ______ Hepatitis B ______ Influenza (flu shot) ______ MMR ______ Pneumovax (pneumonia) ______

Meningitis ______ Tetanus (Td) _____ Varicella (chicken pox) shot or illness ______ Tdap (tetanus & pertussis) _____

HEALTH MAINTENANCE SCREENING TESTS:
Lipid (cholesterol) ________________________________ Date ________________ Abnormal? □ Yes □ No
Sigmoidoscopy __________ or Colonoscopy ___________ Date ________________ Abnormal? □ Yes □ No
Women: Mammogram ____ Date _______ Abnormal? □ Yes □ No Pap Smear ____ Date ________Abnormal? □ Yes □ No
Dexascan (osteoporosis) ____ Date _____ Abnormal? □ Yes □ No
Men: PSA (prostate) ________________________ Date _______________ Abnormal? □ Yes □ No

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates).
_____ Heart disease:
specify type __________________
_____ Asthma/Lung disease
_____ Cancer: (specify): _______________________________
_____ High blood pressure
_____ Diabetes
_____ Other: (specify): _______________________
_____ High cholesterol
_____ Thyroid problem
_____ Kidney disease

SURGICAL HISTORY: Please list all prior operations (with dates):

____

Hospitalizations: List any hospitalizations you have had

Date	Cause	Hospital-Location

Patient and Family History: List family members who have had any of the following. (Includes: mother, father, brother, sister, grandparents.)

	Self	Family	
• Diabetes	□	□	Who? ______________________________
• High Blood Pressure	□	□	Who? ______________________________
• Stroke	□	□	Who? ______________________________
• Heart Problems	□	□	Who? ______________________________
• Cancer	□	□	Who? ______________________________
• Tuberculosis	□	□	Who? ______________________________
• Depression	□	□	Who? ______________________________
• Mental Illness	□	□	Who? ______________________________
• Lung Problems (Asthma, COPD)	□	□	Who? ______________________________
• Seizure	□	□	Who? ______________________________
• Alcoholism	□	□	Who? ______________________________
• Kidney Disease	□	□	Who? ______________________________
• Arthritis	□	□	Who? ______________________________
• Thyroid Problems	□	□	Who? ______________________________
• Other	□	□	Who? ______________________________

Nutritional Screening:
_______No problem _________Diabetic ______ Not eating _____Takes liquids only
_______Nausea _________Trouble chewing or swallowing _______ History of Eating Disorder
_______Special Diet:_____________________________ Other:___________________________________
_______Dental Problems Last Dental Visit: _____________________________________

OVER PLEASE

Substance Use:

Substance	**No**	**Yes**	**If yes, list type i.e coffee and how much**		**Substance**	**None**	**Past**	**Current**	**How Often**
Caffeine					Sedatives				
Tobacco					Inhalants				
Substance	**None**	**Past**	**Current**	**How often**	Cocaine				
Alcohol					Heroin				
Marijuana					Stimulants				
Hashish					Other				

Sexual Activity
Sexually active: □ Yes □ No □ Not currently
Current sex partner(s) is/are: □ male □ female
Birth control method: _______________ □ None needed
Have you ever had any sexually transmitted diseases (STDs)? □ No □ Yes
Are you interested in being screened for sexually transmitted diseases? □ No □ Yes

OTHER CONCERNS

Weight: Are you satisfied with your weight? □ Yes □ No

Diet: How do you rate your diet? □ Good □ Fair □ Poor
Do you eat or drink four servings of dairy or soy daily or take calcium supplements? □ Yes □ No

Exercise: Do you exercise regularly? □ Yes □ No
What kind of exercise? ______________________________
How long (minutes) _______________ How often? ______________
If you do not exercise, why? ________________________________

Safety: Do you use a bike helmet? □ Yes □ No
Do you use seatbelts consistently? □ Yes □ No
Is violence at home a concern for you? □ Yes □ No
Have you ever been abused? □ Yes □ No
Do you have a gun in your home? □ Yes □ No

Have you completed a living will or durable power of attorney for health care? □ Yes □ No

SOCIOECONOMICS Occupation: ___________________________________ Employer: __________________________________

Marital Status: Single Partner/Married Divorced Widowed Other: _______________________________

Spouse/partner's name: _____________________________________ Number of children/ages: ___________________________

Domestic Situation:

With whom do you live?____
Are you able to care for yourself? Yes _____ No ______

Females Only:

Have you ever been pregnant? Yes □ No □ If yes, How many times? _____________________________
deliveries ________________ # miscarriages ________________
How many living children do you have? _____________________
Have you ever had an abortion? Yes □ No □ If yes, When? ______________________________________
Age at start of periods: ___________ Age at end of periods: ___________