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Adult Health History

We recognize you may have previously provided us with some of this information. We appreciate your cooperation in being thorough as possible so that we may include any details that may have been missed before. Please bring the completed form with you on the day of your appointment & give it to the medical assistant who escorts you to the exam room. If uncomfortable with any question, do not answer it. If you cannot remember details, just provide a best guess. Thank you!

Name _____ Your Provider is: _____
Last First Middle Initial

Date of Birth _____ Age_____ Today's Date_____

By what name would you like to be called? _____

CONTACT: Please *** around *** your preferred contact method. May we leave message? □ No □ Yes

Home (____)_____ Cell (___)_____Email_____

My #1 TOP priority to be accomplished today is! (e.g. "Find new ways to deal with stress!" Renew my prescription." "Find out why my knee hurts. " Discuss diet." "Get a physical for insurance". "Update my pap."etc.)

_____

2. Have you ever had any **allergic reaction (bad effects) to a medicine** or a shot?

☐ No, I am not allergic to any medicines. ☐ Yes. (Please write the name of the medicine &the effect)

Medicine I am allergic to	**What happens when I take that medicine**
Example: Atenolol	I get a rash

3. Prescription Medicines Pharmacy:

Name of medicine	**Amount /size of pill**	**How many pills or doses do you take at**
		___morning ____noon ___dinner ___bed
		___morning ____noon ___dinner ___bed
		___morning ____noon ___dinner ___bed
		___morning ____noon ___dinner ___bed
		___morning ____noon ___dinner ___bed

Please use the back of this form if you have more prescription medicines. List Vitamins, supplements, minerals, over the counter medicines like ibuprofen, antacids, etc., on the back, & bring them in with you so we may write them all down. THANKS!

4. PAST MEDICAL HISTORY

Please describe and give dates of any problems, issues, to follow, illnesses, conditions, injuries, hospitalizations, and surgeries: [We have filled in one that we believe is important for everyone!]

1.Preventative Health Care: Lifelong

2.

3.

4.

5.

6.

Surgery and Hospital Stays:

1.

2.

3.

4.

5.

5. WOMEN'S HEALTH HISTORY (Men go to #6)

Do you have menstrual periods currently? Yes □ No □

If no, at what age did they stop? _____ if yes, are your periods regular? Yes □ No □

When was your last menstrual period? _____ Do you have any sexual concerns? Yes □ No □

Have you ever been pregnant? Yes □ No □ Total number of pregnancies: ___ Number of births: _____

How many miscarriages? _____ How many abortions? _____

How many children do you have living? _____ Ages of children now? _____

Women: Do you do regular breast self-exam? Yes □ No □

Women only: Mammogram Date_____ Abnormal? Yes □ No □

Pap Smear Date _____ Abnormal? Yes □ No □ Bone Density Test? Date_____

Birth Control Method_____ History STD? Yes □ No □ Want testing for STD? Yes □ No □

Other concerns not listed? Yes □ No □ _____

6. MEN'S HEALTH HISTORY (Women go to #7)

Do you have any sexual concerns? □ No □ Yes

Birth Control Method_____ History STD? Yes □ No □_ Want testing for STD? Yes □ No □

Do you do regular testicular self-exam? Yes □ No □

7. VACCINES – EVERYONE!

Do you know when your last dT or Tdap was? (Tetanus **booster)** Year____ □ never □ don't know
Do you get yearly Flu Vaccine? Yes □ No □ □ don't know
If senior citizen have you had both types of **Pneumonia shots** Yes □ No □ □ don't know
If diabetic, have you had a Hepatitis B series? Yes □ No □ □ don't know
At risk or need a shingles vaccine? Yes □ No □ □ don't know

8. Lipid (cholesterol) Date _____ Abnormal? □ No □ Yes

9. Colonoscopy Date _____ Polyp? Yes □ No □ Family Hx colon cancer or polyps? Yes □ No □ Don't know □

10. MOOD In the past 2 weeks, have you been bothered by:

Little interest or pleasure in doing things? □ No □ Yes
Feeling down, depressed or hopeless? □ No □ Yes

11. SAFETY QUESTIONS (MORE Questions? Oh No!)

Feel Safe at home? Yes □ No □ □ Tough question
Do you wear your seatbelt: Always___ Sometimes___ Never___
Do you wear sunscreen? □ No □ Yes Ever Complete Skin check? Date_____

12. Last Dental check-ups? _____ Last eye doctor visit? _____

13. SOCIAL HISTORY Are you: Single☐ Married☐ Divorced☐ Separated☐ Widowed☐

Who lives in your house?_____
Children's name: _____
Current job: _____ Previous job: _____ Hobbies?_____

14. HABITS: SMOKING: Never Smoked☐ Former Smoker☐ Current Smoker ☐

(Specify) Cigarettes Amt Daily _____Cigars Amt Daily _____ Smokeless Tobacco Amt Daily _____
a. When did you start smoking? (Age)_____(date)_____
b. Have you quit?..... Yes□ No□, when_____
c. Do you want to quit?..... Yes □ No □ Already Quit □

ALCOHOL: Do you drink alcohol? □ No □ Yes # of drinks/week: _____ □ Beer □ Wine □ Liquor
Have you ever felt you ought to cut down on your drinking? □ No □ Yes

OTHER: Use marijuana or recreational drugs? □No □Yes Have you ever used needles to inject drugs? □ No □ Yes

CAFFIENE: Amount of coffee, soda, energy drinks, tea a day? _____None___

DIET: Rate your daily diet (Great! Good, Too much fast food, etc) _____

EXERCISE Type of exercise_____ How often and how long each time_____

SLEEP Quality and total nightly hours: _____

15. FAMILY HISTORY: Please indicate whether your family members are living or deceased. If deceased, please give the age at death and cause if known: [If alive put Yes!] and current age

	Mom	Dad	Sis(s)	Bro(s)	Kids	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Aunt	Uncle
Alive now? Age?											
Deceased. When?											
Age at death											
Cause of Death											

Are you adopted? □ No □ Yes if adopted, do you know any of your family history? □ No □ Yes

Not adopted but Family History unknown_____

Please indicate any MEDICAL HISTORY in your family members

	Mom	Dad	Sis(s)	Bro(s)	Kids	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Aunts	Uncles	Other
Alcohol/ Drug												
Alzheimer's/ Dementia												
Anesthesia												
Aneurysm												
Arthritis												
Lung												
Bipolar												
Bleeding-Clotting												
Blood Pressure												
Breast Cancer												
Colon Cancer												
Colon Polyps												
Depression/ Anxiety												
Diabetes												
Heart Disease												
Cholesterol												
Melanoma												
Migraine												
Osteoporosis												
Ovarian Cancer												
Prostate Cancer												
Stroke												

REVIEW OF SYMPTOMS: Please mark the box and/or circle any persistent symptoms you have had in the past few months.

GENERAL ☐ No problems
- ☐ Unexplained weight loss / gain
- ☐ Unexplained fatigue / weakness
- ☐ Fall asleep during day
- ☐ Fever, chills
- ☐ Night Sweats

SKIN ☐ No problems
- ☐ New skin lesions
- ☐ Change in mole
- ☐ Rash / itching
- ☐ Dry/ sensitive
- ☐ Sores that won't heal

CARDIOVASULAR ☐ No problems
- ☐ High Blood Pressure
- ☐ Chest pain / discomfort
- ☐ Palpitations (fast or irregular heartbeat)
- ☐ Difficulty Breathing
- ☐ Lightheaded or Faint
- ☐ Swelling
- ☐ Leg Pain with Walking
- ☐ Cold Extremities
- ☐ History Heart Attack
- ☐ Rheumatic Fever

RESPIRATORY ☐ No problems
- ☐ Cough ☐ Wheeze
- ☐ Loud snoring or altered breathing during sleep
- ☐ Short of breath with exertion
- ☐ Pain with Breathing
- ☐ Pneumonia
- ☐ Asthma
- ☐ Tuberculosis (TB)
- ☐ Emphysema COPD)
- ☐ Sleep Apnea

EARS/NOSE/THROAT ☐ No problems
- ☐ Nosebleeds
- ☐ Nasal Congestion or Drainage
- ☐ Loss of Taste
- ☐ Mouth or Lip Sores
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Ear Pain
- ☐ Sinus Infections
- ☐ Chronic congestion
- ☐ Chronic snoring

EYES ☐ No problems
- ☐ Loss of Vision ☐ Double Vision
- ☐ Spots or Floaters
- ☐ Sensitive to Light
- ☐ Itchy Eyes
- ☐ Excessive Tearing ☐ Eye Pain
- ☐ Redness ☐ Dry Eyes
- ☐ Eye Discharge

GASTROINTESTINAL ☐No problems
- ☐ Pain
- ☐ Nausea ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in appetite
- ☐ Blood in bowel movement
- ☐ Stool leakage
- ☐ Ulcer (Peptic, Gastric)
- ☐ Heartburn
- ☐ Irritable Bowel
- ☐ Colon Polyps
- ☐ Pancreatitis
- ☐ Hepatitis
- ☐ Cirrhosis

GENOURINARY ☐ No problems
- ☐ Pain with urination
- ☐ Leaking urine
- ☐ Blood in urine
- ☐ Increased urge to urinate
- ☐ Nighttime urination
- ☐ Increased frequency
- ☐ Unable to empty bladder
- ☐ Concern with sexual function
- ☐ Inability to Achieve Erection
- ☐ Genital Herpes
- ☐ Recurrent bladder infections
- ☐ History Kidney Stones
- ☐ History Kidney Infections

HEMO/ONCOLOGY ☐ No problems
- ☐ Excessive Bruising
- ☐ Excessive Bleeding
- ☐ Anemia
- ☐ Blood Coagulation

MUSCULOSKELATAL ☐No problems
- ☐ Neck pain ☐ Back pain
- ☐ Muscle Pain ☐ Joint Pains
- ☐ Muscle Stiffness
- ☐ Muscle Cramping
- ☐ Muscle Weakness
- ☐ Difficulty w/ Walking

ENDOCRINE ☐ No problems
- ☐ Heat or cold sensitivity
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ Change in Appetite
- ☐ Hair or Nail Changes
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ High Cholesterol

Breast ☐ No problems
- ☐ Breast lump/pain
- ☐ Nipple discharge

NEUROLOGICAL ☐ No problems
- ☐ Headache
- ☐ Memory loss
- ☐ Dizziness
- ☐ Numbness / tingling
- ☐ Unsteady gait
- ☐ Tremor
- ☐ Stroke
- ☐ Seizure

ALLERGIC/IMMUNE ☐ No problems
- ☐ Hay fever / allergies
- ☐ Hives
- ☐ Asthma

PSYCOLOGICAL ☐ No problems
- ☐ Depression
- ☐ Moodiness
- ☐ Alcoholism
- ☐ Anxiety / stress / irritability
- ☐ Sleep problem
- ☐ Lack of concentration
- ☐ Stress
- ☐ Memory Loss
- ☐ Hallucinations
- ☐ Suicidal Thoughts

RHEUMATOLOGIC ☐ No Problems
- ☐ Chronic Back Pain
- ☐ Joint swelling or pain
- ☐ Joint redness
- ☐ Arthritis
- ☐ Gout

MALE Only ☐ No Problems
- ☐ Testicular Mass or Pain
- ☐ Trouble Start/stop stream
- ☐ Difficulty w/ Erections
- ☐ Discharge or Itching

FEMALES Only ☐ No Problems
- ☐ Painful Periods
- ☐ Heavy/long periods
- ☐ Pain w/ Intercourse
- ☐ Vaginal Discharge or Itchy

Clinic Use Only
Reviewed By: _____
Date: _____