ADULT HEALTH HISTORY

(Use for ages 18 and over)

Your answers on this form will help your provider understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. Thank You.

Patient Name:____ Today's Date:______________________

Date of Birth:__________Age:_____ How would you rate your general health? Excellent Good Fair Poor

Main reason for today's visit: ____

Other concerns I would like to discuss today: ____

REVIEW OF SYSTEMS Please check any CURRENT symptoms you have.

General
- Recent fevers/sweats
- Unexplained weight loss/gain
- Unexplained tiredness/weakness

Eyes
- Change in vision

Ears/Nose/Throat/Mouth
- Difficulty hearing/ringing in ears
- Hayfever/allergies/congestion
- Trouble swallowing

Heart/Cardiovascular
- Chest pains/discomfort
- Palpitations
- Short of breath with activity

Breast
- Breast lump
- Nipple discharge

Lungs/Respiratory
- Cough/wheeze
- Coughing up blood

Gastrointestinal
- Heartburn/reflux
- Blood or change in bowel movements
- Nausea/vomiting/diarrhea
- Pain in abdomen

Genitourinary
- Painful/bloody urination
- Leaking urine/weak urine stream
- Nighttime urination
- Discharge: penis or vagina
- Unusual vaginal bleeding
- Concern with sexual function

Musculoskeletal
- Muscle/joint pain
- Recent back pain

Skin
- Rash
- New or change in mole

Neurological
- Headaches
- Memory loss
- Fainting/falling

Psychiatric/Emotional
- Anxiety/stress
- Sleep problems

Blood/Lymph
- Unexplained lumps
- Easy bruising/bleeding

Endocrine
- Cold/heat sensitive
- Increased thirst/appetite

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

CURRENT MEDICATIONS: Please list all medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	Dose (mg/pill)	Times/day	Medication	Dose (mg/pill)	Times/day

ALLERGIES or reactions to medications:

Pharmacy: (Name and Location)

Date of your most recent IMMUNIZATIONS: Influenza (flu shot) Pneumovax (pneumonia) Tetanus (Td)

Tdap (tetanus & pertussis) Hepatitis A Hepatitis B MMR Meningitis

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Patient Name: Date:

PERSONAL MEDICAL HISTORY: Please note if you have had any of the following medical problems

Heart disease:	High blood pressure	High cholesterol
Specify type:	Diabetes	Thyroid problem
Heart attack	Cancer (type)	Kidney disease
Asthma/lung disease	Other (specify)	Birth defects

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

FAMILY HISTORY: Please note family members (mother, father, sister, brother, aunt, uncle, grandparent

Alcoholism/Drug abuse	High cholesterol
Illegal Drug Use	High blood pressure
Heart disease	Stroke
Depression/suicide	Bleeding/clotting
Mental Illness	disorder Asthma/COPD
Diabetes	Other

SOCIAL HISTORY:

TOBACCO USE: Never Quit date

Current smoker: packs/day #of years

Other tobacco: Pipe Cigar Snuff

Chew Vaping

Plan to quit? Now Sometime later

No/never

ALCOHOL USE:

Do you or any household members drink alcohol?

No If Yes, who?

Socially #drinks/week

DRUG USE/ADDICTION:

Do you or any household members use illegal drugs?

No Yes

If Yes, who?

Name of drug?

Does anyone in your household have an addiction to a drug or prescription medication?

No If Yes, who?

Name of drug/medication

OTHER CONCERNS:

CAFFEINE USE: None Coffee/tea/soda cups/day

Weight: Are you satisfied with your weight? No Yes

Diet: How do you rate your diet? Good Fair Poor

EXERCISE: Do you exercise regularly? No Yes, how often?

What kind of Exercise? Minutes per day

If you do not exercise, Why?

SAFETY: Do you use a bike/motorcycle helmet? NA No Yes

Do you regularly wear seatbelts? No Yes

Is there violence in the home? No Yes

Have you ever been abused? No Yes

Do you have a gun in your home? No Yes

SEXUAL ACTIVITY:

Sexually active? No Yes Not currently

Current sex partner(s) is/are: Male Female

Birth control method? None needed

Have you ever had any sexually transmitted diseases (STD's)? No Yes

Interested in being screened for STD's? No Yes

Do you have a completed living will or power of attorney for health care? No Yes

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HEALTH MAINTENANCE/SCREENING TESTS:

General: Yearly dental visits? No Yes Date of last checkup? Unknown

Do you take Calcium? No Yes Do you take Aspirin? No Yes

Have you had any of the following tests? Select each box that applies and enter date and result of most recent test.

	Test			
	Lipid (cholesteral) test	Abnormal?	No	Yes
	Sigmoidoscopy or Colonoscopy	Abnormal?	No	Yes
	Stool for occult blood (3 samples)	Abnormal?	No	Yes
Men:	PSA (prostate)	Abnormal?	No	Yes
Women:	Mammogram	Abnormal?	No	Yes
	Clinical breast exam	Abnormal?	No	Yes
	Pap smear	Abnormal?	No	Yes
	Dexascan/bone density	Abnormal?	No	Yes

Age at start of periods: First day of last menstrual period: Age at end of periods:

Do you have problems with your period or birth control? No Yes,

List number of pregnancies: Deliveries: Abortions/miscarriages: Living children/ages:

If post menopause or over age 50, do you take:

Calcium? No Yes Estrogen? No Yes Progesterone? No Yes

What OB/GYN physician do you see?

SOCIAL/ECONOMIC: Occupation: Employed No Yes

Do you have any communication requirements like needing sign language or translation services: No Yes

Highest year of education: Preferred Method of learning: Written Verbal Visual

Marital status: Single Married/partnered Divorced Widowed Other Spouse/Partner's name:

Number of children (ages): Who lives at home with you?

Daily Living Activities and Nutrition:

Can you bath and dress yourself? No Yes Do you need assistance walking? No Yes

Any food allergies? No Yes What food?

Are you able to cook for yourself? No Yes

Are you able to shop for yourself? No Yes Are you able to feed yourself? No Yes

Do you have chewing, swallowing, or mouth problems that make it hard to eat? No Yes

Have you unintentionally lost or gained 10 or more pounds in the last 6 months? No Yes

Signature of person completing this form: Relationship?