

Name _____

Date _____

Adult Health History Form

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

Respiratory

- ___ Cough/wheeze
- ___ Coughing up blood

Skin

- ___ Rash
- ___ New or change in mole

Eyes

- ___ Change in vision

Gastrointestinal

- ___ Heartburn/reflux
- ___ Blood or change in bowel movement
- ___ Nausea/vomiting/diarrhea
- ___ Pain in abdomen

Neurological

- ___ Headaches
- ___ Memory loss
- ___ Fainting

Ears/Nose/Throat/Mouth

- ___ Difficulty hearing/ringing in ears
- ___ Hay fever/allergies/congestion
- ___ Trouble swallowing

Genitourinary

- ___ Painful/bloody urination
- ___ Leaking urine
- ___ Nighttime urination
- ___ Discharge: penis or vagina
- ___ Unusual vaginal bleeding
- ___ Concern with sexual functions

Psychiatric

- ___ Anxiety/stress
- ___ Sleep problem

Cardiovascular

- ___ Chest pains/discomfort
- ___ Palpitations
- ___ Short of breath with exertion

Blood/Lymphatic

- ___ Unexplained lumps
- ___ Easy bruising/bleeding

Breast

- ___ Breast lump
- ___ Nipple discharge

Musculoskeletal

- ___ Muscle/joint pain
- ___ Recent back pain

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: _____

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

- OVER -

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates).

___ Heart disease: _____
 specify type _____
___ Asthma/Lung disease _____
 ___ High blood pressure _____
 ___ Diabetes _____
 ___ Other: (specify): _____
 ___ High cholesterol _____
 ___ Thyroid problem _____
 ___ Kidney disease _____
 ___ Cancer: (specify): _____

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

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____ High cholesterol _____
Cancer, specify type _____ High blood pressure _____
Heart disease _____ Stroke _____
Depression/suicide _____ Bleeding or clotting disorder _____
Genetic disorders _____ Asthma/COPD _____
Diabetes _____ Other: _____

SOCIAL HISTORY

Tobacco Use

Cigarettes Never Quit Date _____
 Current Smoker: packs/day _____ # of yrs _____
Other Tobacco: Pipe Cigar Snuff Chew
Are you interested in quitting? No Yes

Alcohol Use

Do you drink alcohol? No Yes # drinks/week _____
Is your alcohol use a concern for you or others? No Yes

Drug Use

Do you use any recreational drugs? No Yes
Have you ever used needles to inject drugs? No Yes

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

SOCIOECONOMICS

Occupation: _____ Employer: _____
Years of education/highest degree: _____ Marital Status: Single Partner/Married Divorced Widowed Other: _____
Spouse/partner's name: _____ Number of children/ages: _____
Who lives at home with you? _____

WOMEN'S HEALTH HISTORY

pregnancies _____ # deliveries _____ # abortions _____ # miscarriages _____
Age at start of periods: _____ Age at end of periods: _____

Date of last menstrual cycle - _____
Date of last mammogram - _____

OTHER CONCERNS

Caffeine Intake: 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

Do you eat or drink four servings of dairy or soy daily or take calcium supplements? No Yes

Exercise: Do you exercise regularly? No Yes

What kind of exercise? _____

How long (minutes) _____ How often? _____

If you do not exercise, why? _____

Safety: Do you use a bike helmet? No Yes NA

Do you use seatbelts consistently? No Yes

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 or durable power of attorney for health care? Yes No