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

Eyes
____ Change in vision

Ears/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 or 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: _____

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

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

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: _____

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