

Adult Health History

NEED ASSISTANCE TO COMPLETE? Yes No

Please list the reason for your visit today: _____

ALLERGIES

LIST ANY REACTIONS TO MEDICATIONS, FOOD, LATEX, DYE, ETC. 1. _____ 2. _____ 3. _____

MEDICATIONS

| LIST ALL CURRENT MEDICATIONS INCLUDING NON-PRESCRIPTION DRUGS, HERBS & SUPPLEMENTS | NAME | STRENGTH | HOW OFTEN | NAME | STRENGTH | HOW OFTEN |
|--|------|----------|-----------|------|----------|-----------|
| | 1. | | | | 6. | |
| 2. | | | | 7. | | |
| 3. | | | | 8. | | |
| 4. | | | | 9. | | |
| 5. | | | | 10. | | |

PATIENT PAST MEDICAL HISTORY

| | | | |
|---|--|---|--|
| Alcohol/Drug Problem . <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol . . . <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/Intestinal Problems . <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease . . . <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental Problems. . . <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease . . . <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma/Emphysema. <input type="checkbox"/> Yes <input type="checkbox"/> No | Hereditary Diseases . <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure. <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

ADDITIONAL MEDICAL PROBLEMS / PREVIOUS HOSPITALIZATIONS / SURGERIES / SERIOUS INJURIES

| | | |
|----------------------|----------------------|-----------------------|
| 1. _____ Date: _____ | 5. _____ Date: _____ | 9. _____ Date: _____ |
| 2. _____ Date: _____ | 6. _____ Date: _____ | 10. _____ Date: _____ |
| 3. _____ Date: _____ | 7. _____ Date: _____ | 11. _____ Date: _____ |
| 4. _____ Date: _____ | 8. _____ Date: _____ | 12. _____ Date: _____ |

SOCIAL HISTORY

Marital status: Single Married Separated Divorced Widowed

Last Grade Completed: _____ Occupation: _____

Do you currently smoke? Yes – Pks/day _____ # Years: _____

In the past? No Yes – when stopped: _____

Other tobacco products – List: _____

Do you drink Coffee/Tea/Cola: No Yes – List amount: _____

Do you drink alcohol: No Yes – Amount per week: _____

Have you ever used recreational drugs: No Yes

Do you have any of the following:

Living Will Healthcare Power of Attorney Other Advance Directive

Religious practices or customs which are important to me: _____

FAMILY MEDICAL HISTORY (Refer to Patient Past Medical History for Diseases)

| | Age | Name | Diseases | If Deceased, Cause of Death |
|-------------|-------|-------|----------|-----------------------------|
| Father | _____ | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ | _____ |
| Brother(s)/ | _____ | _____ | _____ | _____ |
| Sister(s) | _____ | _____ | _____ | _____ |
| Children | _____ | _____ | _____ | _____ |
| Spouse | N/A | _____ | N/A | N/A |

IMMUNIZATION HISTORY

Flu Vaccine (Date): _____ Pneumovax Vaccine (Date): _____ Last Tetanus (Date): _____ Hepatitis Vaccine (Date): _____

MISCELLANEOUS

Please list any other provider you are currently seeing: _____

Who referred you to us? _____

Please list any other concerns you may have: _____

PLEASE FLIP PAGE TO COMPLETE

Name: _____ Date of Birth: _____

Date Completed: _____ Reviewed by: _____ MD / DO / ARNP / PA

SYSTEM REVIEW

Please check below if any of the following symptoms are current or recent.

CONSTITUTIONAL

- Good general health lately Yes No
Frequent Fever Yes No
Fatigue. Yes No

EYES

- Sensitive to lights Yes No
Changes in vision Yes No
Wear glasses/contact lenses Yes No

EARS / NOSE/ MOUTH / THROAT

- Hearing loss or ringing Yes No
Earaches or drainage Yes No
Nasal stuffiness/sneezing Yes No
Frequent nose bleeds Yes No
Mouth sores Yes No
Bad breath or bad taste. Yes No
Sore throat or voice change. Yes No
Swelling in neck Yes No

CARDIOVASCULAR

- Low exercise tolerance Yes No
Chest pain or angina pectoris. Yes No
Rapid heart beat/skipped beats. Yes No
Shortness of breath with activity or lying flat Yes No
Swelling of feet, ankles or hands Yes No

RESPIRATORY

- Chronic or frequent coughs Yes No
Coughing up blood Yes No
Wheezing Yes No

GASTROINTESTINAL

- Loss of appetite Yes No
Abdominal pain or heartburn Yes No
Change in bowel habits Yes No
Regular use of laxatives. Yes No
Rectal bleeding or blood in stool Yes No

******NUTRITIONAL STATUS******

- Special Diet:_____ Yes No
Use of Liquid Nutritional Supplements Yes No
Chewing/Swallowing Difficulty Yes No
Unintentional Weight Loss > 10 lbs. in 3 months. Yes No
Unintentional Weight Gain. Yes No
Nausea/Vomiting and/or diarrhea > 5 days Yes No

GENITOURINARY

- Frequent/burning/painful urination Yes No
Blood in urine Yes No
Change in force of stream when urinating Yes No
Incontinence or dribbling Yes No
Male - penile discharge or sores Yes No
Male - testicle pain or lumps Yes No
Sexual difficulty Yes No

GENITOURINARY continued

- Female - pain with periods Yes No
Female - irregular periods Yes No
Female - vaginal discharge Yes No
Female - # pregnancies: _____
Female - # miscarriages: _____
Female - date of last pap smear: _____
Female - date of last menstrual period: _____

MUSCULOSKELETAL

- Joint pain/stiffness/swelling Yes No
Weakness of muscles or joints Yes No
Muscle pain or cramps Yes No
Back pain Yes No
Use of Assistive Device Yes No

ACTIVITIES

- Normal
Type Used: Brace/Splint Crutches Wheelchair Walker
 Cane Prosthesis Other: _____
Assistance required with daily living activities Yes No

INTEGUMENTARY

- Rash or itching Yes No
Change in moles Yes No
Change in hair or nails Yes No
Varicose veins Yes No
Breast pain/lump/discharge. Yes No

NEUROLOGICAL

- Frequent or recurring headaches Yes No
Lightheaded or dizzy Yes No
Convulsions or seizures Yes No
Tremors Yes No
Speech problems Yes No
Balance problems Yes No
Memory loss or confusion. Yes No
Numbness or tingling sensations Yes No

PSYCHIATRIC

- Nervousness or anxiety Yes No
Sleep poorly Yes No
Often depressed. Yes No
Change in moods Yes No
Lifestyle change (divorce, death, loss of job) Yes No
Considered/attempted suicide Yes No
Violence in your home. Yes No

ENDOCRINE

- Night sweats. Yes No
Excessive thirst or urination. Yes No
Heat or cold intolerance. Yes No
Skin becoming dryer Yes No

HEMATOLOGICAL / LYMPHATIC

- Slow to heal after cuts Yes No
Bleed or bruise easy. Yes No
Past transfusion Yes No
Enlarged glands Yes No