

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