

_____ *Name* _____ *Date*

Adult Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. **Thank You.**

Date of Birth: _____ 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

- ___ Unexplained weight loss/gain
- ___ Recent fevers/sweats
- ___ Unexplained fatigue/weakness
- ___ Recent chills/cold sweats

Genitourinary

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

Ophthalmology

- ___ Change in vision
- ___ Eye pain

Cardiology

- ___ Chest pains/discomfort
- ___ Palpitations
- ___ Decreased exercise tolerance

Gastroenterology

- ___ Heartburn/reflux
- ___ Bloody stools
- ___ Change in bowel movement
- ___ Nausea/vomiting/diarrhea
- ___ Pain in abdomen

Psychology

- ___ Anxiety/stress
- ___ Sleep problems

Dermatology

- ___ Rash
- ___ New or change in mole

Respiratory

- ___ Cough/wheeze
- ___ Coughing blood
- ___ Short of breath with exertion
- ___ Pain with breathing

Endocrinology

- ___ Cold/heat intolerance
- ___ Increase thirst/appetite

Musculoskeletal

- ___ Muscle/joint pain
- ___ Recent back pain
- ___ Weakness
- ___ Swollen joints

Women

- ___ No periods
- ___ Heavy periods
- ___ Painful periods
- ___ Irregular periods
- ___ Unusual vaginal bleeding

ENT

- ___ Change in hearing
- ___ Congestion
- ___ Sinus pain
- ___ Sore throat

Neurology

- ___ Memory loss
- ___ Headaches
- ___ Fainting
- ___ Numbness/tingling in hands/feet
- ___ Loss of balance

Date of last period: _____

Menopause at age: _____

Hematology/Lymph

- ___ Unexplained lumps
- ___ Easy bruising/bleeding

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/Vitamin/Supplement	Dose/Strength (e.g., mg/pill)	How many times per day

ALLERGIES: Do you have allergies or reactions to:

Medications	Reaction
_____	_____
_____	_____
_____	_____

Foods	Reaction
_____	_____
_____	_____
_____	_____

IMMUNIZATIONS: Date of most recent record.

Hepatitis A _____ Hepatitis B _____ Influenza (flu shot) _____ MMR _____ Pneumovax (pneumonia) _____
Meningitis _____ Tetanus (Td) _____ Varicella (chicken pox) shot or illness _____ Tdap (tetanus & pertussis) _____

HEALTH MAINTENANCE: Date of most recent record.

Cholesterol _____ Abnormal? Yes No
Colonscopy _____ Abnormal? Yes No
Bone Density Scan _____ Abnormal? Yes No
Women: Mamogram _____ Abnormal? Yes No Pap Smear _____ Abnormal? Yes No
Men: PSA (prostate) _____ Abnormal? Yes No

MEDICAL HISTORY:

SURGICAL HISTORY:

Major Illnesses: (i.e. high blood pressure, high cholesterol, depression, etc.)	Year of Diagnosis	Currently Treated?	Surgeries:	Year of Surgery	Reason for Surgery
1			1		
2			2		
3			3		
4			4		
5			5		
6			6		
7			7		
8			8		

FAMILY HISTORY: 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/clotting disorder _____
Genetic disorders _____	Asthma/COPD _____
Diabetes _____	Anxiety _____
Kidney disease _____	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? Yes No

Alcohol Use

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

Drug Use

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

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)?
 Yes No
Are you interested in being screened for sexually transmitted diseases? Yes No

Caffeine Intake: None Coffee/tea/soda _____ cups/day

Weight: Are you satisfied with your weight? Yes No

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? Yes No

Exercise: Do you exercise regularly? Yes No

What kind of exercise? _____

How long (minutes) _____ How often? _____

If you do not exercise, why? _____

SOCIOECONOMICS:

Occupation: _____

Employer: _____

Marital Status: Single Partner/Married Divorced

Widowed Other: _____

Number of children/ages: _____

WOMENS HEALTH HISTORY

Pregnancies: _____

Deliveries: _____

Abortions: _____

Miscarriages: _____

Age at start of periods: _____ Age at end of periods: _____

