

## 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* (osteoporosis) \_\_\_\_\_ Date \_\_\_\_\_ Abnormal? ☐ Yes ☐ No

Men: *PSA* (prostate) \_\_\_\_\_ Date \_\_\_\_\_ Abnormal? ☐ Yes ☐ No

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

____ Heart disease: <i>specify type</i> _____	____ High blood pressure	____ High cholesterol
____ Asthma/Lung disease	____ Diabetes	____ Thyroid problem
	____ Other: (specify): _____	____ 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: \_\_\_\_\_

### **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