

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