

Adult Health History

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it.

Name _____ Date _____

Home Address _____

_____ Birth date _____

Emergency contact _____

Primary care physician _____ Phone _____

Specialty physician _____ Phone _____

Specialty physician _____ Phone _____

Allergies _____

Medications _____

Significant baseline physical findings _____

Significant baseline ancillary findings (lab, radiography, ECG): _____

Medications to be avoided and why: _____

Procedures to be avoided and why: _____

REVIEW OF SYMPTOMS: Please mark the box and/or circle any persistent symptoms you have had in the past few months. Read through every section and check "no problems" if none of the symptoms apply to you.

General

- Unexplained weight loss / gain
- Unexplained fatigue / weakness
- Fall asleep during day when sitting
- Fever, chills
- No problems

Skin

- New or change in mole
- Rash / itching
- No problems

Breast

- Breast lump / pain / nipple discharge
- No problems

Ears/Nose/Throat

- Nosebleeds, trouble swallowing
- Frequent sore throat, hoarseness
- Hearing loss / ringing in ears
- No problems

Eyes

- Change in vision / eye pain / redness
- No problems

Cardiovascular

- Chest pain / discomfort
- Palpitations (fast or irregular heartbeat)
- No problems

Respiratory

- Cough / wheeze
- Loud snoring / altered breathing during sleep
- Short of breath with exertion
- No problems
- Gastrointestinal
- Heartburn / reflux / indigestion
- Blood or change in bowel movement
- Constipation
- No problems

Genitourinary

- Leaking urine
- Blood in urine
- Nighttime urination or increased frequency
- Discharge: penis or vagina
- Concern with sexual function
- No problems
- Musculoskeletal
- Neck pain
- Back pain
- Muscle / joint pain _____
- No problems

Endocrine

- Heat or cold sensitivity
- No problems

Hematologic/Lymphatic

- Swollen glands
- Easy bruising
- No problems

Neurological

- Headache
- Memory loss
- Fainting
- Dizziness
- Numbness / tingling
- Unsteady gait
- Frequent falls
- No problems

Allergic/Immune

- Hay fever / allergies
- Frequent infections
- No problems

Psychiatric

- Anxiety / stress / irritability
- Sleep problem
- Lack of concentration
- No problems

Women only

- Pre-menstrual symptoms (bloating cramps, irritability)
- Problem with menstrual periods
- Hot flashes / night sweats
- No problems

IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information. ?

Tetanus (Td) With Pertussis (Tdap) Varicella (Chicken Pox) shot or illness Pneumovax (pneumonia) Influenza (flu shot) Hepatitis A Hepatitis B MMR Meningitis Zostavax (shingles) HPV

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) Date _____ Abnormal? ? No ? Yes
Sigmoidoscopy or Colonoscopy (circle one) Date _____ Polyp? ? No ? Yes

Women only:

Mammogram Date _____ Abnormal? ? No ? Yes
Pap Smear Date _____ Abnormal? ? No ? Yes
Bone Density Test Date _____ Abnormal? ? No ? Yes

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you had (past) any of the following conditions?

NONE

Condition	Current	Past	Comments
Alcohol / Drug abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			

Arthritis (Osteoarthritis)			
Asthma			
Bladder / Kidney Problems			
Blood Clot (leg)			
Blood Clot (lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer Breast			
Cancer Colon			
Cancer Other Type			
Cancer Ovarian			
Cancer Prostate			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema			
Fractures (broken bones)			Where?
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Gout			
Gynecological Conditions (Endometriosis)			
Gynecological Conditions (Fibroids)			
Gynecological Conditions (Other)			
Heart Attack			
Hepatitis – Type A			
Hepatitis – Type B			
Hepatitis – Type C			
Hepatitis – Other			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease / Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate (enlargement)			
Prostate (nodules)			
Seizure / Epilepsy			
Skin Condition (Eczema)			
Skin Condition (Psoriasis)			
Skin Condition (Abnormal Moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid High (Overactive) / Hyperthyroidism			
Thyroid Low (Underactive) / Hypothyroidism			
Other (list)			
Other (list)			

(e.g. heart attack, angina)										
Depression / Suicide / Anxiety										
Diabetes (childhood onset)										
Diabetes (adult onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
High Blood Pressure - Hypertension										
High Cholesterol										
Hip Fracture										
Hypothyroidism / Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Other (list)										

OTHER HEALTH ISSUES:

Tobacco Use Smoke cigarettes: Never No Yes
 (If you never smoked please go to alcohol use question now)
 Quit date: _____ How many years did you smoke? _____
 Approximately how many packs a day did you smoke? _____
 Current smoker: Packs/day: _____ # of years: _____
 Other tobacco: Pipe Cigar Snuff Chew

Alcohol Use
 Do you drink alcohol? No Yes
 # of drinks/week: _____ Beer Wine Liquor

Drug Use
 Do you use marijuana or recreational drugs? No Yes
 Have you ever used needles to inject drugs? No Yes

Sexual Activity
 Sexually involved currently: No Yes
 Sexual partner(s) is/are/have been: male female
 Birth control method (circle below all that apply): None needed
 Condom, pill, diaphragm, vasectomy, other _____

Exercise: Do you exercise regularly? Yes No
 What kind of exercise? _____ How long (minutes)? _____ How often? _____

Diet: How would you rate your diet? Good Fair Poor
 Would you like advice on your diet? No Yes

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____
 Date (month/day if known) of last menstrual period if you are still menstruating: _____
 Age at beginning of periods (menstruation): _____
 Age at end of periods (menopause): _____