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ADULT HEALTH HISTORY

Today's Date: _____

Patient's Name: _____ Age: _____ Birthdate: _____

Marital Status: ☐S ☐M ☐W ☐D ☐Sep. ☐Partner Race: _____ Education (Grade Completed): _____

Occupational Status: ☐Homemaker ☐Unemployed ☐Student ☐Employed (Describe) _____

Medications Taken Regularly/Dose: _____

Past Hospitalizations, Surgeries, Dates & Obstetric History:

Ongoing Medical Problems:

Allergies (to drugs such as penicillin): _____

IMMUNIZATIONS/TESTS/EXAMS

			DATES
Tetanus:	Y	N	_____
TB Tine Test:	Y	N	_____
Influenza Vaccine:	Y	N	_____
Pneumonia Vaccine:	Y	N	_____
Hepatitis:	Y	N	_____
Bad Reaction to a Shot?	Y	N	_____
If so, which one?	Y	N	_____
Colonoscopy:	Y	N	_____
Breast X-Ray (Mammogram):	Y	N	_____
Bone Density Scan:	Y	N	_____
Cholesterol Test:	Y	N	_____
Physical Exam:	Y	N	_____
Sigmoidoscopy:	Y	N	_____
Glaucoma Test:	Y	N	_____
Hearing Test:	Y	N	_____

PERSONAL HABITS

			AMOUNT
Smoke:	Y	N	_____
Drink Alcohol:	Y	N	_____
Use Street Drugs/Marijuana:	Y	N	_____
Drink Coffee/Cola:	Y	N	_____
Exercise:	Y	N	_____
Use Sunscreen:	Y	N	_____
Domestic Abuse:	Y	N	_____
Seat Belt:	Y	N	_____
Guns in the House:	Y	N	_____

PERSONAL HEALTH Are you troubled by any of the following?

1. GENERAL

Extreme Tiredness	Y	N
Unexplained Weight Loss	Y	N
Extreme Thirst	Y	N
Lumps or Swelling	Y	N

Where? _____

Other _____

2. SKIN & HAIR

Repeated Skin Rash	Y	N
Repeated Sores	Y	N
Moles that Have Changed Size & Color	Y	N

Other _____

3. EYES, EARS, NOSE & THROAT

Loss of Hearing	Y	N
Ringing in your Ears	Y	N
Disturbance in Vision	Y	N
Repeated Nose Bleed	Y	N
Long Term Nasal Stuffiness or Drainage	Y	N
Severe Dental Problems	Y	N
Hoarseness or Voice Changing	Y	N
Trouble Swallowing	Y	N

Other _____

4. HEART, LUNGS & CIRCULATION

Chronic Cough	Y	N
Coughing Up Blood	Y	N
Abnormal Chest X-Ray	Y	N
Wheezing	Y	N
Chest Pain	Y	N
Shortness of Breath	Y	N
Irregular Heart Beat	Y	N
Heart Murmur	Y	N
Leg Cramps While Walking	Y	N
Ankle Swelling	Y	N

Other _____

5. STOMACH & BOWELS

Poor Appetite	Y	N
Heartburn	Y	N
Repeated Abdominal Pain	Y	N
Tarry (Black) Stool	Y	N
Frequent Nausea or Vomiting	Y	N
Changes in Bowel Movements	Y	N
Constipation	Y	N
Frequent Diarrhea	Y	N
Rectal Bleeding	Y	N

Other _____

6. KIDNEY, BLADDER, REPRODUCTIVE

Difficult or Painful Urination	Y	N
Urination More than Once a Night	Y	N
Trouble Holding Urine	Y	N
Repeated Bladder or Kidney Infection	Y	N
Blood in Urine	Y	N
History of Kidney Stone	Y	N
Problem with Sex Function	Y	N
Sores or Discharge	Y	N
Problems Having Children	Y	N
Sexually Active	Y	N

If Yes, type of contraception used

_____

Other _____

7. SKELETON & JOINTS

Swollen or Painful Joints	Y	N
Gout	Y	N
Back Trouble	Y	N
Difficulty Walking	Y	N
Bursitis or Tendonitis	Y	N

Other _____

8. NERVOUS SYSTEM

Frequent or Severe Headaches	Y	N
Loss of Balance	Y	N
Unexplained Dizziness	Y	N
Fainting (Blackout)	Y	N
Head Injury	Y	N
Twitching or Tremors (Shaking)	Y	N
Numbness or Tingling in Hands or Feet	Y	N
Stress or Nervousness	Y	N
Feeling Depressed	Y	N
Thoughts of Suicide	Y	N
Trouble Concentrating or Remembering	Y	N
Have You Had Counseling?	Y	N
Do You Desire Counseling?	Y	N

Other _____

9. OTHER PROBLEMS/CONCERNS

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

HAVE YOU OR ANY OF YOUR FAMILY HAD ANY OF THE FOLLOWING?

(Including parents, brothers, sisters, grandparents)

		RELATIONSHIP (If YES)	
Glaucoma	Y	_____	N
Asthma	Y	_____	N
Chronic Bronchitis or Emphysema	Y	_____	N
Heart Disease	Y	_____	N
High Blood Pressure	Y	_____	N
Phlebitis (Blood Clots in Legs)	Y	_____	N
Pneumonia	Y	_____	N
Stroke	Y	_____	N
Tuberculosis	Y	_____	N
Anemia or Low Blood Count	Y	_____	N
Bleeding Problems	Y	_____	N
Colitis	Y	_____	N
Kidney or Bladder Infections	Y	_____	N
Liver Disease or Hepatitis	Y	_____	N

		RELATIONSHIP (If YES)	
Ulcer (Stomach or Duodenal)	Y	_____	N
Diabetes	Y	_____	N
Thyroid Disorder	Y	_____	N
Arthritis (Pain or Stiffness in Joints)	Y	_____	N
Infectious Mononucleosis (Mono)	Y	_____	N
Rheumatic Fever	Y	_____	N
Sexually Transmitted Disease	Y	_____	N
Epilepsy (Seizures or Convulsions)	Y	_____	N
Alcohol/Drug Problems	Y	_____	N
Mental Health Problems (Depression, Anxiety, etc.)	Y	_____	N
Cancer	Y	_____	N

Type of Cancer _____

Other Serious Illnesses (Describe) _____

_____

WOMEN ONLY

Irregular Periods	Y	N
Severe Cramps	Y	N
Last Pap Smear	Date _____	
Abnormal Smear	Date _____	
Last Mammogram	Date _____	
Mammogram Received at	_____	
Number of Pregnancies	_____	
Number of Deliveries	_____	
Abortion/Miscarriage	Y	N
Birth Control	Y	N
Post Menopausal	Y	N
Last Menstrual Period	Date _____	

MEN ONLY

Swelling or Tenderness of the Scrotum or Testicles	Y	N
Prostate Trouble	Y	N
Vasectomy	Y	N

PATIENT SIGNATURE _____

Physician Comments:

PHYSICIAN SIGNATURE _____