

Adult Health History

Name: _____ DOB: _____ Sex: M F

Check all items that apply to you and fill in blanks as needed.

Past Medical History

- | | |
|---|---|
| <input type="checkbox"/> Allergies (other than drugs), _____ | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Anemia or Blood problems | <input type="checkbox"/> Hypothyroid or Hyperthyroid |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Inherited disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney disease or stone |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Blood transfusion, when _____ | <input type="checkbox"/> Mental illness or Depression |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Ovarian cysts |
| <input type="checkbox"/> Cancer/Tumor, explain _____ | <input type="checkbox"/> Pap smear, abnormal |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> Colon disease | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Diabetes, type _____, how long _____ | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Drug or Alcohol abuse | <input type="checkbox"/> Sexually transmitted disease (STD) |
| <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Sickle cell anemia or trait |
| <input type="checkbox"/> Glaucoma or Cataracts | <input type="checkbox"/> Skin disease, eczema, psoriasis |
| <input type="checkbox"/> Headaches, type _____ | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Heart disease or heart attack | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hepatitis, A B C or Jaundice | <input type="checkbox"/> _____ |

Past Surgical & Hospitalization History

- | | |
|--|---|
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Hysterectomy (uterus) |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Knee, R or L, procedure _____ |
| <input type="checkbox"/> Back, procedure _____ | <input type="checkbox"/> Ovaries removed |
| <input type="checkbox"/> Breast, R or L, procedure _____ | <input type="checkbox"/> Psychiatric treatment, inpt or outpt |
| <input type="checkbox"/> Cervical freezing or LEEP | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Fracture, _____ | <input type="checkbox"/> Tubal ligation (Tubes tied) |
| <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Hernia, R or L, type _____ | Other: _____ |

Females Only: Age at first period: _____ yrs. old Birth control method _____
Number of: Pregnancies _____ Deliveries _____ Miscarriages _____ Abortions _____
Date of last: Period _____ Pap smear _____ Mammogram _____

Drug allergies: No Known Drug Allergies

<u>Name of Drug</u>	<u>Reaction</u>
_____	_____
_____	_____
_____	_____

(Turn page over for more questions)

Current Medications: (prescription, over-the-counter, herbs, vitamins, recreational):

<u>Medication</u>	<u>Strength/Dose</u>	<u>Frequency</u>	<u>Medication</u>	<u>Strength/Dose</u>	<u>Frequency</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Immunizations: Tetanus booster _____ Flu vaccine _____ Other _____
 (year received) Pneumovax _____ Hepatitis B _____

Social History:

Marital Status: Married Divorced Single Separated Widow

Occupation: _____ Highest level of education: _____

Tobacco: Never Cigarettes/snuff _____; how much/day _____; how long _____; Quit, when _____

Alcohol: Number of drinks or bottles of beer per week _____

Caffeine: Number of cups of coffee _____/day, glasses tea _____/day, sodas _____/day

Sexually active: Yes No New partner in the last year? Yes No

Victim of abuse: physical sexual mental Who is abuser? _____

Seat belt use: Yes No Firearms in home: Yes No; Locked-up: Yes No

Exposure to hazardous materials: _____ Travel to foreign countries: _____

Special diet or vegetarian: _____

Death in family in the last year? Yes No Relationship _____

Members of household: _____

Family History:

	Living		Deceased	
	<u>Age</u>	<u>Health status or illness</u>	<u>Age</u>	<u>Cause of death & illnesses</u>
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Father's father	_____	_____	_____	_____
Father's mother	_____	_____	_____	_____
Mother's father	_____	_____	_____	_____
Mother's mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____

Patient Signature _____ Date _____

Provider Review: Signature _____ Date _____