Adult Health History for New Patients

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date form completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other health concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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. List other concerns above.

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| *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

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| \_\_\_ 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 period \_\_\_ Hot flashes / night sweats **\_\_\_ No problems**  |

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**MEDICATIONS:** Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there.

□ **TAKE NO MEDICATIONS**

Medication Dose (e.g. mg/pill) How many times per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Allergies or intolerance to medications (include type of reaction): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ **NONE**

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

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| **SURGICAL HISTORY** – Please check off any procedure or surgeries. List any abnormal finding or complications. □ NONE |
| Surgical Procedure |  | Year | Comments |
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| **Tobacco Use** |
| Smoke Cigarettes: Never No Yes |
| (If you never smoked please go to alcohol use questions 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 (please circle): Pipe Cigar Snuff Chew |
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| **Alcohol** |
| Do you drink alcohol? No Yes # drinks/week: \_\_\_\_\_\_\_\_ |
| Beer Wine Liquor |
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| **Drug use** |
| Do you use marijuana or recreational drugs? No Yes |
| Have you ever used needles to inject drugs? No Yes |
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| **Exercise** |
| Do you exercise regularly No Yes  |
| What kind of exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often \_\_\_\_\_\_\_\_\_\_\_\_ |
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| Have you completed an Advance Directive for Health Care, Living Will or POLST (Physician Orders for Life Sustaining Therapy)? NO YES |
| Do you have a Power of Attorney? No Yes Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Social History** |
| Occupation (or prior occupation): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Retired/unemployed/leave of absence/disabled (circle one) |
| Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Years of education or highest degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Marital Status (circle one): single/married/divorced/widowed/other |
| Spouse's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Number of children: \_\_\_\_\_\_\_\_\_ Grandchildren \_\_\_\_\_\_\_\_\_ Great grandchildren \_\_\_\_\_\_ |
| Who lives at home with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Leisure activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **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): \_\_\_\_\_\_\_\_\_ |

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| **Health Insurance** |
| Name of Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Account Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name insurance is under \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medicare No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medicaid No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| Additional Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| Social Security No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| People who can receive information regarding your medical/speech therapy care |
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| Name | Relationship | Phone |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |
| People who should be contacted in case of emergency |  |
|  |  |  |
| Name | Relationship | Phone |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |
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