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   |  | | --- | | \_\_\_ 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** | |

**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 |
|  |
| **Alcohol** |
| Do you drink alcohol? No Yes # 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 |
|  |
| **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. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| Additional Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| Social Security No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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