Adult Health History Form

Name: Date:

Your answers will help your care provider better understand your medical concerns and conditions. If you are uncomfortable with any questions, by right you do not have to answer. If you cannot remember specific details, please provide your best guest. Thank you!

**Name of your previous primary care provider(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Symptoms**: Please circle yes or no below for any symptoms you have or have had in the past.

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| **Constitutional**  Recent fevers/sweats? ☐ Yes ☐ No  Weight loss/gain? ☐Yes ☐No  Fatigue/weakness? ☐ Yes ☐ No  **Eyes**  Change in vision? ☐Yes ☐ No  **Cardiovascular**  Chest pains/ discomfort? ☐ Yes ☐No  Palpitations? ☐ Yes ☐ No  Short of breath with exertion?☐Yes☐No  Heart Murmur? ☐ Yes ☐ No  **Breast**  Breast lump? ☐ Yes ☐ No  Nipple discharge? ☐ Yes ☐ No  **Respiratory**  Cough/wheeze? ☐ Yes ☐ No  Coughing up blood? ☐ Yes ☐ No  Snoring? ☐ Yes ☐ No  **Gastrointestinal**  Nausea/vomiting? ☐ Yes ☐ No  Heartburn/reflux? ☐ Yes ☐ No  Pain in abdomen? ☐ Yes ☐ No  Gas/bloating? ☐ Yes ☐ No  Blood in stool? ☐ Yes ☐ No  Change in bowel habits? ☐ Yes ☐ No  Diarrhea/ constipation? ☐ Yes ☐ No  Hemorrhoids? ☐ Yes ☐ No | **Genitourinary**  Painful/blood urination? ☐Yes ☐ No  Leaking urine? ☐Yes ☐ No  Frequent nighttime urination? ☐Yes ☐No  Sexual frustration? ☐Yes ☐No  **Musculoskeletal**  Muscle/ join pain? ☐ Yes ☐ No  Swelling/stiffness of joints? ☐ Yes ☐ No  **Skin**  Rash? ☐ Yes ☐ No  New or change in mole? ☐ Yes ☐ No  **Neurological**  Headaches? ☐ Yes ☐ No  Memory changes? ☐ Yes ☐ No  Fainting? ☐ Yes ☐ No  Seizures? ☐ Yes ☐ No  Lightheadedness? ☐ Yes ☐ No  Disequilibrium? ☐ Yes ☐ No  **Psychiatric**  Anxiety? ☐ Yes ☐ No  Depression? ☐ Yes ☐ No  Sleep problem? ☐ Yes ☐ No  Trouble concentrating? ☐ Yes ☐ No  **Blood/ Lymphatic**  Unexplained lumps? ☐ Yes ☐ No  Easy bruising/bleeding? ☐ Yes ☐ No | **Ears/Nose/Throat/Mouth**  Difficulty hearing? ☐Yes ☐ No  Ringing in ears? ☐Yes ☐ No  Nose bleed? ☐Yes ☐ No  Trouble swallowing? ☐Yes ☐ No  **Endo**  Cold/heat intolerance? ☐Yes ☐ No  Appetite changes? ☐ Yes ☐No  **Women only**  Abnormal Pap smear? ☐ Yes ☐ No  Bleeding between periods? ☐ Yes ☐ No  Extreme menstrual pain? ☐ Yes ☐ No  Hot flashes? ☐ Yes ☐ No  Painful intercourse? ☐ Yes ☐ No  Vaginal discharge? ☐ Yes ☐ No  **Pregnancies? How many?** \_\_\_\_\_\_   * Miscarriages \_\_\_\_\_ * Live births \_\_\_\_ * Abortions \_\_\_\_\_   **Men only**  Difficulties with erection? ☐ Yes ☐ No  Difficulties with ejaculation? ☐ Yes ☐ No  Lump in testicles? ☐ Yes ☐ No  Penis discharge? ☐ Yes ☐ No  **Please provide the dates:**  **Lipid: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Pap Smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **PSA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Bone Density Test: \_\_\_\_\_\_\_\_\_\_\_\_\_**  **Eye Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Dental Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

In the past month, have you had little interest or pleasure in doing things, or felt down, or hopeless? **Yes/No**

How would you rate your general health? (Please circle one): **Excellent/ Good/ Fair/ Poor**

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| Please list **any medications** you are currently taking: (prescription, non-prescription, vitamins, birth control, home remedies, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Please list any **allergies** you may have or **reactions** to medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Personal Medical History:** Please indicate whether you have had any of the following medical problems.

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| Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Asthma/ Lung disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  High cholesterol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Thyroid problem \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Kidney disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  High blood pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Surgical History:** Please list all prior operations, with dates. (invasive and non-invasive).  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Immunizations:** Please provide dates.  Tetanus (Td): \_\_\_\_\_\_\_ MMR: \_\_\_\_\_\_\_ HPV: \_\_\_\_\_\_\_  Varicella: \_\_\_\_\_\_\_\_ Meningitis: \_\_\_\_\_\_\_\_ Hep B: \_\_\_\_\_\_  Pneumonia: \_\_\_\_\_\_\_ Shingles: \_\_\_\_\_\_\_ Influenza: \_\_\_\_\_ |

**Family History**: Please indicate the current health status of your immediate family.

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| Father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mother \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Siblings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please indicate which family members (parent, sibling, grandparent, aunt and/or uncle) that have the following conditions:

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| High cholesterol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  High blood pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Heart disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Bleeding or clotting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Breast cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Colon cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Malignant melanoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Osteoporosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Depression \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Alcoholism \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Demographics:**

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| **Married** ☐  **Single** ☐  **Occupation**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Tobacco Use?** ☐ Yes ☐ No   * Duration? \_\_\_\_\_\_\_\_ months \_\_\_\_\_\_\_\_\_ years * Did you quit? Yes/No When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Do you want to quit? Yes/ No/ Eventually   **Alcohol Use?** ☐ Yes ☐ No   * How much do you consume? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Is it becoming a problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **Recreational Drug Use?** ☐ Yes ☐ No   * How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Sexually Active?** Yes/ No/ Not currently   * Current sex partner? Male/Female * Use of birth control? ☐ Yes ☐ No * Contracted STD’s (sexually transmitted diseases)?   ☐ Yes ☐ No  **Caffeine Intake?** ☐ Yes ☐ No  If so: How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **How is your diet?** ☐Good ☐ Fair ☐Poor  **Do you exercise?** Yes/ No   * How often? ☐Regularly ☐Not often   **Is Violence at home a concern for you?** ☐ Yes ☐ No |

Comments/Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_