Name _____ Date _____

Adult Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. **Thank You.**

Date of Birth: _____ How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Main reason for today's visit: _____
Other concerns: _____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional
____ Unexplained weight loss/gain
____ Recent fevers/sweats
____ Unexplained fatigue/weakness
____ Recent chills/cold sweats

Cardiology
____ Chest pains/discomfort
____ Palpitations
____ Decreased exercise tolerance

Dermatology
____ Rash
____ New or change in mole

Endocrinology
____ Cold/heat intolerance
____ Increase thirst/appetite

ENT
____ Change in hearing
____ Congestion
____ Sinus pain
____ Sore throat

Hematology/Lymph
____ Unexplained lumps
____ Easy bruising/bleeding

Genitourinary
____ Painful/bloody urination
____ Leaking urine
____ Nighttime urination
____ Discharge: penis or vagina
____ Concern with sexual functions

Gastroenterology
____ Heartburn/reflux
____ Bloody stools
____ Change in bowel movement
____ Nausea/vomiting/diarrhea
____ Pain in abdomen

Musculoskeletal
____ Muscle/joint pain
____ Recent back pain
____ Weakness
____ Swollen joints

Neurology
____ Memory loss
____ Headaches
____ Fainting
____ Numbness/tingling in hands/feet
____ Loss of balance

Opthalmology
____ Change in vision
____ Eye pain

Psychology
____ Anxiety/stress
____ Sleep problems

Respiratory
____ Cough/wheeze
____ Coughing blood
____ Short of breath with exertion
____ Pain with breathing

Women
____ No periods
____ Heavy periods
____ Painful periods
____ Irregular periods
____ Unusual vaginal bleeding

Date of last period: _____
Menopause at age: _____

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

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication/Vitamin/Supplement	Dose/Strength (e.g., mg/pill)	How many times per day

ALLERGIES: Do you have allergies or reactions to:

Medications	Reaction	**Foods**	Reaction
_____		_____	
_____		_____	
_____		_____	

IMMUNIZATIONS: Date of most recent record.

Hepatitis A _____ Hepatitis B _____ Influenza (flu shot) _____ MMR _____ Pneumovax (pneumonia) _____
Meningitis _____ Tetanus (Td) _____ Varicella (chicken pox) shot or illness _____ Tdap (tetanus & pertussis) _____

HEALTH MAINTENANCE: Date of most recent record.

Cholesterol _____ Abnormal? □ Yes □ No
Colonoscopy _____ Abnormal? □ Yes □ No
Bone Density Scan _____ Abnormal? □ Yes □ No
Women: Mamogram _____ Abnormal? □ Yes □ No Pap Smear _____ Abnormal? □ Yes □ No
Men: PSA (prostate) _____ Abnormal? □ Yes □ No

MEDICAL HISTORY:

Major Illnesses: (i.e. high blood pressure, high cholesterol, depression, etc.)	Year of Diagnosis	Currently Treated?
1		
2		
3		
4		
5		
6		
7		
8		

SURGICAL HISTORY:

Surgeries:	Year of Surgery	Reason for Surgery
1		
2		
3		
4		
5		
6		
7		
8		

FAMILY HISTORY: Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____
Cancer, specify type _____
Heart disease _____
Depression/suicide _____
Genetic disorders _____
Diabetes _____
Kidney disease _____
High cholesterol _____
High blood pressure _____
Stroke _____
Bleeding/clotting disorder _____
Asthma/COPD _____
Anxiety _____
Other: _____

SOCIAL HISTORY:

Tobacco Use

Cigarettes □ Never □ Quit Date _____
□ Current Smoker: packs/day _____ # of yrs _____
Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Are you interested in quitting? □ Yes □ No

Alcohol Use

Do you drink alcohol? □ Yes □ No # drinks/week _____
Is your alcohol use a concern for you or others? □ Yes □ No

Drug Use

Do you use any recreational drugs? □ Yes □ No
Have you ever used needles to inject drugs? □ Yes □ No

Sexual Activity

Sexually active: □ Yes □ No □ Not currently
Current sex partner(s) is/are: □ male □ female
Birth control method: _____ □ None needed
Have you ever had any sexually transmitted diseases (STDs)? □ Yes □ No
Are you interested in being screened for sexually transmitted diseases? □ Yes □ No

Caffeine Intake: □ None □ Coffee/tea/soda _____cups/day
Weight: Are you satisfied with your weight? □ Yes □ No
Diet: How do you rate your diet? □ Good □ Fair □ Poor
Do you eat or drink four servings of dairy or soy daily or take calcium supplements? □ Yes □ No
Exercise: Do you exercise regularly? □ Yes □ No
What kind of exercise?_____
How long (minutes)_____ How often?_____
If you do not exercise, why?_____

SOCIOECONOMICS:

Occupation:_____
Employer:_____
Martial Status: □ Single □ Partner/Married □ Divorced
□ Widowed □ Other:_____
Number of children/ages:_____

WOMENS HEALTH HISTORY

Preganicies: _____
Deliveries: _____
Abortions: _____
Miscarriages: _____
Age at start of periods: _____ Age at end of periods: _____