

Adult Initial Health History Form

Name _____

First

Middle

Last

Today's Date _____ Date of Birth _____

Address _____

Telephone Number (home) (_____) _____

(cell) (_____) _____

(work) (_____) _____

Filling out this form

- Answering these questions will help your doctor understand your health and how best to treat you.
 - If you need help filling out this form:
 - Bring this form with you to your appointment and a nurse will help you.
- OR
- Call the clinic at 8046164378 before your appointment and someone can help you over the phone.

Bring to your appointment:

1. This **Initial Health History Form** and any other important **medical records**
2. Your **insurance information**
3. All **your medicines** (prescription, herbal, over-the-counter pills, liquids, and creams)

We look forward to working with you!

GENERAL HEALTH

1. **Why did you make this appointment?** (Check all that apply.)

- ☐ Regular checkup
- ☐ First appointment to start care with a new doctor
- ☐ Switching doctors (from whom: _____)
- ☐ Have a specific health problem (if so, explain _____)

2. In general, what do you consider to be your **main health problem(s)**? (Check all that apply.)

- ☐ Heart problems ☐ Diabetes
- ☐ Stomach problems ☐ Depression/emotional problems
- ☐ Ear, nose, or throat problems ☐ Joint problems
- ☐ High blood pressure
- ☐ Other(s) – please explain _____
- _____

3. How would you **describe your health**?

- ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

4. Are you taking any **prescription medicines**?

- ☐ No, I do not take any prescription medicines. (If no, go to question #5.)
- ☐ Yes. Please list your medicines below OR ☐ I brought my pill bottles or a list.

Name of medicine	Amount/size of pill	How many pills or doses do you take at
Example: Furosemide	20 mg	<u> 2 </u> morning <u> 2 </u> noon <u> </u> dinner <u> </u> bed
		<u> </u> morning <u> </u> noon <u> </u> dinner <u> </u> bed
		<u> </u> morning <u> </u> noon <u> </u> dinner <u> </u> bed
		<u> </u> morning <u> </u> noon <u> </u> dinner <u> </u> bed
		<u> </u> morning <u> </u> noon <u> </u> dinner <u> </u> bed
		<u> </u> morning <u> </u> noon <u> </u> dinner <u> </u> bed

(Please use the back of this form if you have more prescription medicines.)

5. What **over-the-counter medicines**, do you take regularly?

- ☐ Pain reliever (for example: Tylenol, Advil, Motrin, Aleve, aspirin)
- ☐ Vitamins
- ☐ Antacid (for example: Tums, Prilosec)
- ☐ Herbal medicine (please list) _____
- ☐ Other (please list) _____
- ☐ None - I do not take any over-the-counter medicines regularly.

6. Have you ever had any **allergic reaction (bad effects) to a medicine** or a shot?

- ☐ No, I am not allergic to any medicines.
- ☐ Yes. (Please write the name of the medicine and the effect you had.)

Medicine I am allergic to	What happens when I take that medicine
Example: Atenolol	I get a rash

7. Do you get an **allergic reaction (bad effect)** from any of the following? (Check all that apply)

- ☐ Latex (rubber gloves)
- ☐ Grass or pollen
- ☐ Eggs
- ☐ Shellfish
- ☐ Other (please describe) _____
- ☐ No - I have no allergies that I know of.

8. Have you ever been a **patient in a hospital** overnight?

☐ No, I have never been a patient in a hospital. (If no, go to question #9)

☐ Yes. (If yes, explain EACH reason and when.)

I was in the hospital because:	When
Example: Heart Attack	6 years ago

9. Have you ever had a **colonoscopy** (a test to look at your insides by sending a camera through your bottom)? ☐ Yes ☐ No

When _____

10. Have you ever received a **blood transfusion** (when you are given extra

blood)? ☐ Yes ☐ No

When _____

FOR WOMEN ONLY

11. Have you ever been **pregnant**? ☐ Yes ☐ No

How many times? _____

How many children have you given birth to? _____

12. Have you had a **PAP smear**? ☐ Yes ☐ No

Date of last one _____

13. Have you ever had a **PAP smear that was not normal**? ☐ Yes ☐ No

14. Have you had a **mammogram** (breast x-ray)? ☐ Yes ☐ No

Date of last one _____

SHOTS

15. When was your last **Tetanus shot**?.....Year_____ ☐Never ☐Don't know

16. When was your last **Pneumonia shot**?..... Year_____ ☐Never ☐Don't know

17. When was your last **Flu shot**?..... Year_____ ☐Never ☐Don't know

SOCIAL HISTORY

18. Circle the **highest grade** you finished in school?

1 2 3 4 5 6 7 8 9 10 11 12 GED 1 2 3 1 2 3 4+
Grade School High School Vocational School College

19. What **language** do you prefer to speak? ☐English ☐Spanish ☐Other _____

20. How well can you **read**?

☐ Very well ☐ Well ☐ Not well ☐ I can not read

21. **What do you do during the day?**

- ☐ Work full-time
- ☐ Work part-time
- ☐ Attend school
- ☐ Take care of children at home
- ☐ Go out most days (shop, visit, appointments)
- ☐ Stay home most days
- ☐ Other_____

22. Have you **ever smoked cigarettes, cigars, used snuff, or chewed tobacco**?

☐ No (if no, go to question #23.)

☐ Yes

a. When did you start?_____

b. How much per week? _____

c. Have you quit?..... ☐ No ☐ Yes, when_____

d. Do you want to quit?..... ☐ No ☐ Yes ☐ Already Quit

23. Do you drink **alcohol**?

☐ No (if no, go to question #24.)

☐ Yes

a. Have you ever felt you ought to cut down on your drinking? ☐ Yes ☐ No

b. Have people ever annoyed you by criticizing your drinking? ☐ Yes ☐ No

c. Have you ever felt bad or guilty about your drinking? ☐ Yes ☐ No

d. Have you ever had a drink first thing in the morning? ☐ Yes ☐ No

24. Are you ☐ Single ☐ Married ☐ Partnered ☐ Divorced or Separated ☐ Widowed?

25. Who lives in your house? _____

26. Do you have **sex** with ☐ men ☐ women ☐ both ☐ neither

27. Do you have any **beliefs or practices from your religion, culture, or otherwise** that your doctor should know? For example:

☐ I do not accept blood/blood products because of personal or religious beliefs.

☐ I **do not use birth control** because of personal or religious beliefs.

☐ I **fast** (go without food) for periods of time for personal or religious reasons.

☐ I do not eat meat.

☐ I do not eat anything that comes from an animal.

☐ Other special diets or eating habits. (Please describe.) _____

☐ I use traditional medicines or treatments, such as acupuncture or herbs.

☐ Other beliefs _____

☐ **No**, I have no specific beliefs or practices that change the course of my health care.

28. Check any of the following things you use to **help you walk**.

☐ Cane ☐ Walker ☐ Wheelchair

☐ Other _____

☐ I do not need any help walking

29. Check any of the following types of **help at home** you receive (paid help or family and friends).

- ☐ Help with cleaning/laundry.
- ☐ Help with shopping.
- ☐ Help with personal care (bathing, dressing).
- ☐ Help with taking my medicines.
- ☐ I do not use any help at home.

30. In the past year, have you been **emotionally or physically abused** by your partner or someone important to you?..... ☐ Yes ☐ No

31. In the past year have you been **hit, pushed, shoved, kicked or threatened** by a partner or someone important to you?..... ☐ Yes ☐ No

32. EXERCISE

Describe what kind of exercise you do. (Check all that apply.)	How many times per week do you exercise?	For how long do you exercise <u>each day</u> ?
<input type="checkbox"/> walking <input type="checkbox"/> biking <input type="checkbox"/> swimming <input type="checkbox"/> weight training <input type="checkbox"/> yoga <input type="checkbox"/> other <input type="checkbox"/> I do not exercise	<input type="checkbox"/> once per week <input type="checkbox"/> twice per week <input type="checkbox"/> 3 times a week <input type="checkbox"/> 4 times a week <input type="checkbox"/> 5 times a week <input type="checkbox"/> 6 times a week <input type="checkbox"/> 7 times a week or more	<input type="checkbox"/> less than 15 minutes <input type="checkbox"/> 15-30 minutes <input type="checkbox"/> 30 – 45 minutes <input type="checkbox"/> 45 minutes – 1 hour <input type="checkbox"/> over 1 hour

Comments:

FAMILY HISTORY

What medical problems do people in your family have?

Family Member	Medical Problems
Mother:	<input type="checkbox"/> Diabetes (sugar) <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart problems <input type="checkbox"/> Cancer <input type="checkbox"/> other: _____
Father:	<input type="checkbox"/> Diabetes (sugar) <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart problems <input type="checkbox"/> Cancer <input type="checkbox"/> other: _____
Sisters:	<input type="checkbox"/> Diabetes (sugar) <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart problems <input type="checkbox"/> Cancer <input type="checkbox"/> other: _____
Brothers:	<input type="checkbox"/> Diabetes (sugar) <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart problems <input type="checkbox"/> Cancer <input type="checkbox"/> other: _____

HISTORY OF MEDICAL CONDITIONS

Have you **ever** had any of the following conditions? (Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia (low iron blood) | <input type="checkbox"/> Asthma (wheezing) | <input type="checkbox"/> Diabetes (sugar) |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Hemorrhoids (piles) | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hepatitis (yellow jaundice) | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Skin problems | <input type="checkbox"/> Depression (feeling down or blue) | |
| <input type="checkbox"/> Epilepsy (fits, seizures) | <input type="checkbox"/> Anxiety (nerves, panic attacks) | |
| <input type="checkbox"/> VD, STD (syphilis, gonorrhea, chlamydia, HIV) | | |
| <input type="checkbox"/> Other _____ | | |

REVIEW OF SYMPTOMS			
Sleeping	Do you feel tired a lot?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have trouble falling or staying asleep ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have other problems with sleep ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eating	Have you lost your appetite recently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you lost weight in the last year without trying?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you eat too much or have you gained weight recently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have other problems with eating ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Throat	Do you have sore throats a lot?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have other problems with your throat ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ears	Do you have trouble hearing ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you wear a hearing aid ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have constant ringing or noises in your ears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have other problems with your ears ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back	Do you have back pain ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have any other problems with your back ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eyes	Do you have trouble with your vision or seeing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you wear glasses or contacts ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have other problems with your eyes ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nose and Sinuses	Do you have a runny or stopped up nose a lot?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have other problems with your nose or sinuses ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Teeth and Mouth	Do you have sore or bleeding gums ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you wear plates or false teeth ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have other problems with your teeth and mouth ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

REVIEW OF SYMPTOMS CONTINUED

Heart or Breathing	Do you ever have pain/tightness in your chest when working or exercising?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you wake up at night with trouble breathing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have a racing or skipping heartbeat at times?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have other heart or breathing problems ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bowel Movements	Do you have bowel movements (poop) that are black, like tar, or bloody ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have any other problems with your bowel movements (poop) ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Peeing and Kidney Stones	Do you have trouble passing your urine (peeing)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Does it burn when you pass urine (pee) ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have to pee more than 2 times a night ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you leak urine (pee) ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever passed kidney stones ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have any other problems with your peeing ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Joints	Do you have swollen or painful joints ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have any other problems with your joints ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

REVIEW OF SYMPTOMS CONTINUED

Head, Balance, Fever and Weakness	Do you have frequent or severe headaches ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever fainted (passed out) ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you lost your balance and fallen recently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have weakness in any part of your body?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you had a fever within the past month?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have any other problems with your head or balance ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emotional Health	Do you get upset easily ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do frightening thoughts keep coming into your mind?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever been hospitalized for nerves, thoughts or moods ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	During the past 2 weeks, have you often been bothered by having little interest or pleasure in doing things ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	During the past 2 weeks, have you often been bothered by feeling down, depressed, or hopeless ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have any other problems with your emotional health ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Men Only	Have you ever had prostate trouble ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have any other male problems ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Women Only	Do you have pain or lumps in your breast ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have unusual vaginal discharge or itching ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you or have you taken hormones (such as birth control pills) ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have any other female problems ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No