

\_\_\_\_\_  
 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

*Genitourinary*

- \_\_\_ Painful/bloody urination
- \_\_\_ Leaking urine
- \_\_\_ Nighttime urination
- \_\_\_ Discharge: penis or vagina
- \_\_\_ Concern with sexual functions

*Ophthalmology*

- \_\_\_ Change in vision
- \_\_\_ Eye pain

*Cardiology*

- \_\_\_ Chest pains/discomfort
- \_\_\_ Palpitations
- \_\_\_ Decreased exercise tolerance

*Gastroenterology*

- \_\_\_ Heartburn/reflux
- \_\_\_ Bloody stools
- \_\_\_ Change in bowel movement
- \_\_\_ Nausea/vomiting/diarrhea
- \_\_\_ Pain in abdomen

*Psychology*

- \_\_\_ Anxiety/stress
- \_\_\_ Sleep problems

*Dermatology*

- \_\_\_ Rash
- \_\_\_ New or change in mole

*Respiratory*

- \_\_\_ Cough/wheeze
- \_\_\_ Coughing blood
- \_\_\_ Short of breath with exertion
- \_\_\_ Pain with breathing

*Endocrinology*

- \_\_\_ Cold/heat intolerance
- \_\_\_ Increase thirst/appetite

*Musculoskeletal*

- \_\_\_ Muscle/joint pain
- \_\_\_ Recent back pain
- \_\_\_ Weakness
- \_\_\_ Swollen joints

*Women*

- \_\_\_ No periods
- \_\_\_ Heavy periods
- \_\_\_ Painful periods
- \_\_\_ Irregular periods
- \_\_\_ Unusual vaginal bleeding

*ENT*

- \_\_\_ Change in hearing
- \_\_\_ Congestion
- \_\_\_ Sinus pain
- \_\_\_ Sore throat

*Neurology*

- \_\_\_ Memory loss
- \_\_\_ Headaches
- \_\_\_ Fainting
- \_\_\_ Numbness/tingling in hands/feet
- \_\_\_ Loss of balance

Date of last period: \_\_\_\_\_

Menopause at age: \_\_\_\_\_

*Hematology/Lymph*

- \_\_\_ Unexplained lumps
- \_\_\_ Easy bruising/bleeding

 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  
Colonscopy \_\_\_\_\_ 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:**

**SURGICAL HISTORY:**

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

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

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

Marital Status:  Single  Partner/Married  Divorced

Widowed  Other: \_\_\_\_\_

Number of children/ages: \_\_\_\_\_

**WOMENS HEALTH HISTORY**

# Pregnancies: \_\_\_\_\_

# Deliveries: \_\_\_\_\_

# Abortions: \_\_\_\_\_

# Miscarriages: \_\_\_\_\_

Age at start of periods: \_\_\_\_\_ Age at end of periods: \_\_\_\_\_

