Name:_____Birth Date:_____Date:_____

ADULT HEALTH HISTORY FORM

Your answers on this form will help your health care provider better understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. **Thank you!**

Name of your previous primary care provider(s):_____

REVIEW OF SYMPTOMS: Please check any symptoms you have or have had in the past.

Constitutional
___Recent fevers/sweats
___Weight loss/gain
___Fatigue/weakness

Eyes
___Change in vision

Ears/Nose/Throat/Mouth
___Difficulty hearing
___Ringing in ears
___Nose bleed
___Trouble swallowing

Cardiovascular
___Chest pains/discomfort
___Palpitations
___Short of breath with exertion
___Heart murmur

Breast
___Breast lump
___Nipple discharge

Respiratory
___Cough/wheeze
___Coughing up blood
___Snoring

Gastrointestinal
___Nausea/vomiting
___Heartburn/reflux
___Pain in abdomen
___Gas/bloating
___Blood in stool
___Change in bowel habits
___Diarrhea/constipation
___Hemorrhoids

Genitourinary
___Painful/bloody urination
___Leaking urine
___Frequent nighttime urination
___Concern with sexual functions

Musculoskeletal
___Muscle/joint pain
___Swelling/stiffness of joints

Skin
___Rash
___New or change in mole

Neurological
___Headaches
___Memory changes
___Fainting
___Seizures
___Lightheadedness
___Disequilibrium

Psychiatric
___Anxiety
___Depression
___Sleep problem
___Trouble concentrating

Blood/Lymphatic
___Unexplained lumps
___Easy bruising/bleeding

Endo
___Cold/heat intolerance
___ Appetite changes

Women only
___Abnormal Pap smear
___Bleeding between periods
___Extreme menstrual pain
___Hot flashes
___Painful intercourse
___Vaginal discharge

Men only
___Difficulties with erection
___Difficulties with ejaculation
___Lump in testicles
___Penis discharge

Women's reproductive history:
___#pregnancies____#live births
___#miscarriages____#abortions

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?
___Excellent
___Good____Fair____Poor

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

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES OR REACTIONS TO MEDICATIONS_____

_____

HEALTH MAINTENANCE SCREENING TESTS: Please provide the dates.

Lipid (cholesterol)_____
Women: Mammogram _____
Pap Smear_____
Men: PSA (prostate specific antigen) _____
Colonoscopy _____
Bone density test_____
Eye exam_____
Dental exam_____

IMMUNIZATIONS: Please provide the dates.

Tetanus (Td)_____MMR_____Varicella_____Meningitis_____HPV_____
Hepatitis B_____Pneumonia_____Shingles_____Influenza (flu)_____

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PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems

___Heart disease_____
___Asthma/Lung disease_____
___High cholesterol_____
___Thyroid problem_____
___Kidney disease_____
___Cancer_____
___High blood pressure_____
___Diabetes_____
___Other_____

SURGICAL HISTORY: Please list all prior operations (with dates):

FAMILY HISTORY: Please indicate the current health status of your immediate family members:

Father_____
Mother_____
Siblings_____
Children_____

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

High cholesterol_____
High blood pressure_____
Heart disease_____
Stroke_____
Diabetes_____
Breast cancer_____
Colon cancer_____
Malignant melanoma_____
Osteoporosis_____
Depression_____
Alcoholism_____
Bleeding or clotting disorder_____
Other_____

SOCIAL HISTORY:

Marital Status_____
Occupation_____
Tobacco Use_____
___Cigarettes___ Pipe___Cigars___Smokeless tobacco
How much do you or did you smoke_____per day?
For how many years?_____
Did you quit?_____ When?_____
Do you wish to quit?___ Yes___No____Eventually
Alcohol Use_____
How much alcohol do you drink?_____
Is your alcohol using a concern for you or others?_____
Recreational Drug Use_____Yes ___No

Sexual Activity_____
Sexually active:___Yes___No___Not currently___Never
Current sex partner(s) is/are:___male___female
Birth control method:_____
Have you ever had any sexually transmitted diseases (STDs)?___Yes___No
Caffeine Intake___None___Coffee/tea/soda cups/day
Diet___Good___Fair___Poor
Exercise____Regularly___No
Safety_____
Do you use a bike helmet?___Yes___No___N/A
Do you use seatbelts consistently?___Yes___No
Is violence at home a concern for you?___Yes___No

OTHER COMMENTS/CONCERNS:

Patient Signature_____Date_____

Physician Signature_____Date_____

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