

ADULT HEALTH HISTORY



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1. ALLERGIES: LIST ALLERGIES TO MEDICATIONS, LATEX, DYE, ETC.

1. _____ 2. _____ 3. _____

PLEASE INDICATE BELOW THE REACTION IT CAUSES:

1. _____ 2. _____ 3. _____

2. MEDICATIONS

LIST ALL CURRENT MEDICATIONS INCLUDING OVER-THE-COUNTER DRUGS, HERBS, SUPPLEMENTS.

NAME	STRENGTH	HOW OFTEN
1.		
2.		
3.		
4.		
5.		

NAME	STRENGTH	HOW OFTEN
1.		
2.		
3.		
4.		
5.		

3. PATIENT PAST MEDICAL HISTORY

CHECK ALL YOUR MEDICAL CONDITIONS

Alcohol Problem <input type="checkbox"/> YES <input type="checkbox"/> NO	Chronic Bronchitis/ Emphysema <input type="checkbox"/> YES <input type="checkbox"/> NO	High Cholesterol <input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke <input type="checkbox"/> YES <input type="checkbox"/> NO
Drug Problem <input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney Disease <input type="checkbox"/> YES <input type="checkbox"/> NO	Thyroid Disease <input type="checkbox"/> YES <input type="checkbox"/> NO
Anemia <input type="checkbox"/> YES <input type="checkbox"/> NO	Glaucoma <input type="checkbox"/> YES <input type="checkbox"/> NO	Mental Problems <input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO
Arthritis <input type="checkbox"/> YES <input type="checkbox"/> NO	Gout <input type="checkbox"/> YES <input type="checkbox"/> NO	Migraines <input type="checkbox"/> YES <input type="checkbox"/> NO	Stomach Problems <input type="checkbox"/> YES <input type="checkbox"/> NO
Asthma <input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Disease <input type="checkbox"/> YES <input type="checkbox"/> NO	Seizures <input type="checkbox"/> YES <input type="checkbox"/> NO	Intestinal Problems: <input type="checkbox"/> YES <input type="checkbox"/> NO
Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO	High Blood Pressure <input type="checkbox"/> YES <input type="checkbox"/> NO		OTHER: _____
If YES to cancer, where: _____			

4. SURGERIES

LIST ALL THE SURGERIES YOU EVER HAD

1. _____ Date: _____ 5. _____ Date: _____ 9. _____ Date: _____
 2. _____ Date: _____ 6. _____ Date: _____ 10. _____ Date: _____
 3. _____ Date: _____ 7. _____ Date: _____ 11. _____ Date: _____
 4. _____ Date: _____ 8. _____ Date: _____ 12. _____ Date: _____

5. SOCIAL HISTORY

MARITAL STATUS: Single Married Separated
 Divorced Widowed

NUMBER OF CHILDREN: _____

OCCUPATION: _____

LAST GRADE COMPLETED: _____

HIGHEST DEGREE RECEIVED: _____

DO YOU HAVE EITHER OF THE FOLLOWING: Living Will
 Healthcare Power of Attorney

DO YOU DRINK ALCOHOL: Yes No
 IF YES ABOVE: Amount per week: _____ Type: _____

DO YOU CURRENTLY SMOKE? Yes No
 IF YES ABOVE: Packs per day: _____ # of years: _____

DID YOU EVER SMOKE? Yes No
 IF YES ABOVE: When stopped: _____ Amount: _____

HAVE YOU EVER USED RECREATIONAL DRUGS? Yes No
 IF YES ABOVE: Type: _____

PLEASE TURN THE PAGE AND COMPLETE THE BACK ►

NAME _____ DATE OF BIRTH _____

REVIEWED BY _____ DATE FORM COMPLETED _____

6. FAMILY MEDICAL HISTORY

	AGE	NAME	DISEASES	IF DECEASED, CAUSE OF DEATH
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____
Spouse	_____	_____	_____	_____

ANY FAMILY HISTORY OF:

Coronary artery disease
 (heart attack, angioplasty, heart surgery): Yes No Whom: _____

High blood pressure: Yes No Whom: _____

Diabetes (blood sugar): Yes No Whom: _____

Cancer: Yes No Whom and What type: _____

7. IMMUNIZATION HISTORY

PLEASE INDICATE THE MOST RECENT YEAR

Flu Vaccine (Date): _____ Pneumovax Vaccine (Date): _____
 Last Tetanus (Date): _____ Hepatitis Vaccine (Date): _____

FOR PATIENTS WITH DIABETES ONLY:
 Last visit to the podiatrist (Date): _____
 Last visit to the ophthalmologist (Date): _____

8. PREVENTATIVE

Colon Cancer Screening Yes No
 IF YES ABOVE: When _____; What type of screen test: _____
 Date of last Bone Density Scan _____

MALES ONLY:

Date of last Rectal Exam _____
 Date of last PSA Level _____

FEMALES ONLY:

Date of last Pap Smear/Pelvic Exam _____ Number of pregnancies _____
 Date of last Mammogram _____ Number of miscarriages _____
 Date of Last menstrual period _____ Birth control method _____

HOW DID YOU HEAR ABOUT US?

NAME _____ **DATE OF BIRTH** _____
REVIEWED BY _____ **DATE FORM COMPLETED** _____