ADULT HEALTH HISTORY (≥17 years old)

DATE: **NAME:** **BIRTH DATE:** **AGE:** **M F**

This form is for background health information. It is part of your medical records and is strictly confidential. 2 PAGES TOTAL.

How may we communicate your results to you? (please circle) **MAIL** **PHONE** **FAX** **ALL**

Who Referred You? **Previous physician:**

Past Medical History

Other doctors that you see? ____

Please check all that apply to you:

Alcoholism	___	**Heart Attack**	___
Allergies/ Hayfever	___	**(Other Heart Trouble)**	___
Anemia/ Bleeding	___	**Hepatitis**	___
Anorexia/ Bulemia	___	**High Blood Pressure**	___
Anxiety	___	**High Cholesterol**	___
Arthritis/ Gout	___	**Kidney Disease**	___
Asthma	___	**Liver Disease**	___
Birth Defects	___	**Mental Illness**	___
Blood Transfusion	___	**Pelvic Problem (women)**	___
Bowel Problems	___	**Prostate Problem (men)**	___
Cancer	___	**Nerve Problem**	___
Circulation Problem	___	**Rheumatic Fever**	___
Depression	___	**Stroke**	___
Diabetes	___	**Tattoos**	___
Emphysema/ COPD	___	**Thyroid Problem**	___
Epilepsy/ Seizures	___	**Tuberculosis (TB)**	___
Frequent Bladder Infections	___	**Ulcers in the Stomach**	___
Gall Stones	___	**Venereal Disease/ STD**	___
Glaucoma	___	**Other Problems**	___
Headaches	___	**Type?:**	

<u>Health Maintenance</u>

FEMALE: **# of Pregnancies? ____** **# of Children? ____**

Last Well-Woman Exam ____ **Mammogram ____** **Bone Density ____**

MALE: **Last Physical Exam ______** **Prostate Exam ______** **PSA Blood Test ______**

ALL: **Last Colonoscopy / Flexible Sigmoidoscopy ____** **Stress Test ____** **Tetanus ____** **Pneumonia Shot ____**

Do you have a LIVING WILL or ADVANCE DIRECTIVE ? ______ **Would you like info ? ______**

Medications **(Please list all medicines, with dosage, that you take *<u>REGULARLY</u>*. Include all pain-relievers, vitamins, supplements and herbs.)**

1.	**3.**	**5.**	**7.**	**9.**
2.	**4.**	**6.**	**8.**	**10.**

Allergies **(Please list any medication or food allergies and the reactions they cause you.)**

1.	**3.**	**5.**
2.	**4.**	**6.**

ADULT HEALTH HISTORY

Surgical History **(Please list all surgeries with approximate dates, including C-sections.)**

1.	**3.**	**5.**	**7.**
2.	**4.**	**6.**	**8.**

Family History **(Please fill in your family's history, if known.)**

	Age	Major health problems	Age at death	Cause of death
Mother	____	________________________	__________	_____________________
Father	____	________________________	__________	_____________________
Brother or Sister	____	________________________	__________	_____________________
Brother or Sister	____	________________________	__________	_____________________
Brother or Sister	____	________________________	__________	_____________________
Brother or Sister	____	________________________	__________	_____________________

Social History

Occupation __________________________ **Employer** _________________________________ **Marital Status** **M** **S** **D** **W**

Children's names ____

Do you use tobacco? ____ **If yes, please circle:** **Cigarettes** **Cigars** **Smokeless** **When did you quit?** ____

Do you drink alcohol? ____ **If yes, please circle:** **Beer** **Wine** **Liquor** **# of drinks per week** ____

How many cups of coffee per day? ____ **Tea?** ____ **Soda?** ____

Do you use cocaine ____, marijuana ____, injected drugs ____, LSD (acid) ____, or speed ____?

What do you do for exercise?

Review of Systems **(Please circle all symptoms that are a problem for you.)**

Const	fever weight loss weight gain fatigue
HEENT	vision problem hearing problem dizziness nose problem hoarseness sore throat
CV	chest pain heart murmur palpitations/skipped beats leg cramps when walking
Resp	shortness of breath cough wheeze
GI	nausea/vomiting heart burn/reflux stomach pain constipation diarrhea blood in stool
GU	problems urinating incontinence erectile dysfunction blood in urine
MS	joint pain muscle pain swelling muscle cramps stiffness
Skin	skin problems hair problems nail problems
Neuro	headache numbness weakness seizures tremor
Psych	anxiety depression hallucinations
Endo	hot or cold intolerance year of menopause ?
Heme	bleeding problem easy bruising anemia
Other	please describe:

Your Signature Here: PLEASE STOP HERE