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?:** _____	

Health Maintenance

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 *REGULARLY*. 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**