Adult History

Help Us Help You

This Health History is an important step in making quality health care available to you and your family. Please answer the questions below. This information will be kept confidential and used for your continuing care.

Please Print

Date: _____ Date of Last Physical Exam: _____

Patients Name: _____ Date Of Birth: _____

Person completing this history: _____

Disease History

Please check any of the following you have or have had

Eye/Ear/Nose
__ Eye pain
__ Double Vision
__ Glaucoma
__ Hearing loss
__ Ringing of ears
__ None
__ Other _____

Heart
__ High Blood Pressure
__ Heart attack
__ Heart murmur
__ Chest Pain
__Shortness of breath
__Chest discomfort with exercise
__Heart disease
__None
__Other

Kidney/Bladder
__Urinate frequently
__Urinary pain or itching
__Urinary infection
__Leakage
__Kidney stones
__Bloody urine
__None
__Other _____

Lungs
__Bronchitis
__Emphysema
__ Sinusitis
__ Phlegm when coughing
__ Asthma
__Tuberculosis (TB)
__Chronic Cough
__ None
__ Other_____

Skin
__Acne
__Dermatitis
__Psoriasis
__Bruise easily
__None
__Other_____

Muscular/Skeletal
__Muscle weakness
__Back/Neck injury
__Backaches
__Broken Bones
__None
__Other _____

Nervous System
__Headaches
__Fainting or dizzy spells
__Epilepsy
__Head injury
__ Nerve injury
__None
__Other _____

Systemic
__Diabetes (sugar)
__Glandular trouble
__ Thyroid
__Unusual lumps
__Nipple discharge
__Stomach/bowel problem
__Hepatitis
__Yellow jaundice
__ Alcoholism
__ Night Sweats
__ AIDS
__ None
__Other _____

Teeth/Mouth
__Mouth sores

__Loose teeth
__Dentures
__None
__ Other _____

Vascular
__Circulation problem
__Anemia
__Sickle cell
__Bleeding tendencies (bleed easily)
__Nose Bleeds
__Calf pain
__ Ankle swelling
__ None
__ Other_____

List any surgeries/ operations (please include the year)
_____

List any allergic reactions or sensitivities to medication_____

List any medications you are currently taking _____
_____
_____

Have you ever had any of the following illnesses:

__Chickenpox __Smallpox __German Measles __Hard Measles __Diphtheria
__Mumps __Scarlet Fever __Strep Throat

Women

Have you had any of the following problems:

__Breast lumps __Discharge from nipples __Vaginal discharge
__Uterine infection __Bleeding between periods __ Abnormal Pap Smears

Age of first period _____
Average number of days of flow _____
Length of time between periods _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____

Number of living children _____
Are you pregnant now? _____
Date of last pap smear _____
Date of last mammogram _____
Have you ever had an abnormal pap smear? _____
Have you ever had an abnormal mammogram? _____
Do you regularly perform self breast exams? ____

Men

Have you had any of the following problems:

__Frequent urination __Testicular pain or swelling __Prostate trouble __Impotence
Do you regularly perform testicular exams? _____

Family History

Please check all that apply	Father	Mother	Father's parents	Mother's parents	Siblings Children
Heart Disease					
High Blood Pressure					
Stroke					
Cancer					
Glaucoma					
Diabetes					
Epilepsy					
Bleeding disorder					
Kidney disease					
Thyroid disease					
Mental illness					
Parkinson's disease					
Alzheimer disease					
Other					

Social History

Do you smoke? _____
Cigars? _____
Cigarettes? _____
How much? _____

Do you drink? _____
Liquor? _____
Beer? _____
How much? _____

Do you use illegal drugs? _____
What kind? _____
How much? _____

Do you use chewing tobacco? _____ How much? _____

Have you ever been treated for alcohol or substance abuse? _____How long ago? _____

Do you drink caffeinated beverages? _____ How much? _____

How often do you exercise? _____

Yes or No

____Do you eat a low fat diet?

____Do you eat a vegetarian diet?

____Do you have a living will?

____Do you wear seat belts?

____Do you wear a helmet while riding a bike or motorcycle?

____Is your time well balanced between work, family, & hobbies?

____ If you have a gun in the home, is it out of children's reach?

____Do you have smoke detectors in your home?

____Is your home tobacco and smoke free?

____Do you practice "safe sex"?

____Are you sad or depressed?

____Are you tense or fearful?

____Are you being abused?

____Are you often dissatisfied with your sexual life?

___Do you ever feel like "ending it all"?

___ Are you at risk for AIDS?

____Have you used illegal drugs?

___Have you had a loss of interest or pleasure in all, or almost all activities most of the day nearly every day?

What is your occupation? _____

Have you ever been exposed to chemicals or radiation at the workplace? _____

Are you often dissatisfied with your work? _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____