ADULT HEALTH HISTORY

THIS INFORMATION WILL BE CONTAINED IN YOUR CONFIDENTIAL MEDICAL RECORd

Last Name:_________________________________ First Name:___________________________________

Today's Date:______________________Birthdate:______________________Gender:___________________

Please list your main reason for seeing the doctor today:____

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Name of your primary doctor:____

Date of last complete checkup:____________________Diagnosis, if any:_________________________________

Please list **prescription medications** that you are currently taking, with dosages:

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

Please list **vitamins, minerals, herbs, homeopathics or supplements** that you are currently taking, with dosages:

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

Do you have any **severe or life threatening allergies**, or sensitivities, or bad reactions to medications, foods, chemicals, animals or anything else? □YES □NO

If YES, please explain: ____

The general state of my health has been: □Excellent □Good □Fair □Poor

Height:___________ Weight:___________ Weight change in past 12 months: gain_____lbs loss_____lbs

Personal Habits

Do you follow any particular diet regimens or restrictions? If yes, please describe: ________________________

____

Caffeine: Coffee ___________cups per day Tea ___________cups per day

Smoking: Packs per day:_______ Number of years:________ Years stopped:_________ cigs/pipe/cigar/chew

Alcohol: What type?_______________________________ How much each week?__________________

Other: Soft drinks? Energy drinks? What type and how much per day?

____

Do you exercise regularly? □ YES □ NO If yes, what type? ____

How Long?____________________________________ How Often? ___________________________________

How many hours do you sleep?____

Occupation:____

Past History

Hospitalizations: ____

____

Serious Illnesses and Injuries: ____

____

Family History

Please indicate whether any of your family members have any of the following health conditions:

Mother (M) Father (F) Brother (B) Sister (S) Grandparent (G) Your Children (C)

	M	F	B	S	G	C		M	F	B	S	G	C
Allergies	□	□	□	□	□	□	Hearing Loss	□	□	□	□	□	□
Alcoholism	□	□	□	□	□	□	High Blood Pressure	□	□	□	□	□	□
Asthma	□	□	□	□	□	□	Hypoglycemia	□	□	□	□	□	□
Bleeding tendency	□	□	□	□	□	□	Kidney Disease	□	□	□	□	□	□
Cancer	□	□	□	□	□	□	Nervous/Mental Disorder	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	Heart Disease	□	□	□	□	□	□

What are your children's names and ages? ____

System Review: Check if you currently have any symptoms or problems to any important or significant degree.

General:
- □ Weight loss/gain
- □ Eating disorder
- □ Appetite change
- □ Tiredness, weakness
- □ Sudden energy drop, time of day
- □ Fever
- □ Sweating at night
- □ Sweating when tired
- □ Bleeding tendency
- □ Bruise easily
- □ Poor sleep
- □ Strong thirst (for hot or cold?)
- □ Cravings

E.E.N.T

DATE OF LAST EYE EXAM:________________
- □ Disturbances of vision
- □ Red or itchy eyes
- □ Loss of hearing
- □ Ringing in ears
- □ Pain in ears
- □ Disturbances of speech
- □ Trouble swallowing
- □ Sore or dry throat
- □ Lip or mouth sores
- □ Nosebleeds
- □ Nose or sinus problems
- □ TMJ
- □ Loss of taste or smell
- □ Headache
- □ Problems with teeth/dentures

DATE OF LAST DENTAL EXAM:____________

Respiratory System:
- □ Cough
- □ Asthma
- □ Chest pain
- □ Shortness of breath
- □ Rib pain

Gastrointestinal System:

DATE OF last urinary or bladder infection:_____________________________
- □ Constipation
- □ Diarrhea
- □ Blood in stool
- □ Hemorrhoids
- □ Nausea, vomiting
- □ Heartburn
- □ Indigestion
- □ Abdominal pain/discomfort
- □ Gas & bloating
- □ Jaundice (yellowing of skin and eyes)

Genitourinary System:
- □ Lower abdominal pain
- □ Kidney problem
- □ Hernia
- □ Sexually transmitted disease
- □ Pain on urination
- □ Inability to hold urine
- □ Blood in urine
- □ Urethral discharge

Women:

Could you be pregnant?______________

DATE OF LAST PERIOD:__________________

TYPE OF BIRTH CONTROL:_______________

DATE OF LAST MAMMOGRAM:___________
- □ Painful periods
- □ PMS
- □ Irregular periods
- □ Excessive bleeding
- □ Abnormal lack of menses
- □ Hot flashes
- □ Vaginal dryness
- □ Sexual difficulties
- □ Painful breasts
- □ Lumps in breasts
- □ Pregnancy#___

Skin and Hair
- □ Rash
- □ Oozing skin sores
- □ Eczema
- □ Loss of hair

Men:

DATE OF VASECTOMY:__________________
- □ Prostate problems
- □ Sexual difficulties
- □ Testicular pain/swelling
- □ Penis pain or discharge

Musculoskeletal System:
- □ Joint pain, swelling
- □ Pain in neck, shoulder, back, arm, hand, hip, buttock, leg, knee, ankle, foot (circle all that apply)
- □ Cold hands or feet
- □ Pins and needles sensation

Cardiovascular System:

DATE of last EKG:_____________________

DATE of last Chest X-ray:_______________
- □ Palpitations
- □ Blood pressure problems
- □ High cholesterol
- □ History or heart murmurs
- □ Swollen ankles or feet
- □ Blood clots

Central Nervous System:
- □ Fainting
- □ Convulsions
- □ Weakness/paralysis
- □ Loss of feeling or function in body part
- □ Disturbances of balance
- □ Dizziness
- □ Light-headedness

Emotional:
- □ Worry
- □ Moodiness
- □ Irritability
- □ Nervousness
- □ Depression
- □ Grief
- □ Problems in relationships

Additions to Health History:

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PATIENT SIGNATURE:____ DATE: _________________________

REVIEWED WITH PATIENT, PHYSICIAN SIGNATURE:____________________________________DATE:_____________