

# ADULT PATIENT HEALTH HISTORY

The information completed on this questionnaire will become a confidential part of your medical record. If you do not want to answer a question, leave it blank and discuss it privately with your doctor at your visit.

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Appt date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Previous Physician: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle

## ALLERGIES

Medications: List/Describe: \_\_\_\_\_

Food  Animals  Latex  Tape  Pollens  Eggs  Iodine  Nuts  
Other: \_\_\_\_\_

## MEDICAL HISTORY

## MEDICATIONS

List all medications you are currently taking which have been ordered by a doctor (including inhalers) and all over the counter drugs, vitamins or herbs. Please list prescribed medications first,

YOUR PHARMACY NAME AND LOCATION: \_\_\_\_\_ Phone \_\_\_\_\_

### Name of Medicine/Dose/Frequency:

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 7 _____  | 13 _____ |
| 2. _____ | 8 _____  | 14 _____ |
| 3. _____ | 9 _____  | 15 _____ |
| 4. _____ | 10 _____ | 16 _____ |
| 5. _____ | 11 _____ | 17 _____ |
| 6. _____ | 12 _____ | 18 _____ |

### IMMUNIZATIONS:

For Adults:

- \_\_\_\_\_ Flu (once annually)  
\_\_\_\_\_ Pneumonia (Once every 5 years)  
\_\_\_\_\_ Tetanus  
\_\_\_\_\_ Shingles (Zostavax)

### ILLNESSES:

Check major, significant illnesses which apply to you:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Emotional/Mental Illnesses | <input type="checkbox"/> Kidney Disease      |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> Kidney Stones       |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Epilepsy/seizures          | <input type="checkbox"/> Liver Disease       |
| <input type="checkbox"/> Bleeding/Blood Disorder | <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Osteoporosis        |
| <input type="checkbox"/> Breast cancer           | <input type="checkbox"/> Hay Fever                  | <input type="checkbox"/> Migraine Headaches  |
| <input type="checkbox"/> Cancer(s) _____         | <input type="checkbox"/> Heart Problems             | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Cataracts               | <input type="checkbox"/> Hepatitis/Jaundice         | <input type="checkbox"/> Thyroid Disease     |
| <input type="checkbox"/> Colitis                 | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Tuberculosis/TB     |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> HIV/AIDS                   | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Constipation            | <input type="checkbox"/> Mononucleosis              | <input type="checkbox"/> Gallbladder disease |

Others: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SURGICAL:**

List the year of any operations/procedures you have had.

	Year		Year
Appendix Surgery	_____	Hip Surgery	_____
Breast growth removal	_____	Hysterectomy	_____
Carpal tunnel	_____	Knee Surgery	_____
Cataract Removal	_____	Nasal/Sinus Surgery	_____
Cesarean section delivery	_____	Plastic Surgery	_____
Colonoscopy (looking into bowel)	_____	Polyp removal from intestine	_____
D & C	_____	Prostate surgery	_____
Gall bladder surgery/laparoscopy	_____	Thyroid surgery	_____
Gastroscopy (looking into stomach)	_____	Tonsils/Adenoids removed	_____
Heart catheterization/surgery	_____	Tubal Ligation	_____
Hernia	_____	Vasectomy	_____
OTHER _____	_____	OTHER _____	_____

**HOSPITALIZATIONS:**

List any other hospitalizations:

Reason: \_\_\_\_\_ Year: \_\_\_\_\_  
Reason: \_\_\_\_\_ Year: \_\_\_\_\_  
Reason: \_\_\_\_\_ Year: \_\_\_\_\_  
Reason: \_\_\_\_\_ Year: \_\_\_\_\_

**TRAUMA/BROKEN BONES/SERIOUS ACCIDENTS:**

Trauma: \_\_\_\_\_ Year: \_\_\_\_\_  
Trauma: \_\_\_\_\_ Year: \_\_\_\_\_  
Trauma: \_\_\_\_\_ Year: \_\_\_\_\_

**OTHER PHYSICIANS:**

List any other doctors (specialists, etc.)you have seen:

\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY**

**ADOPTION:**

Are you adopted?  Yes  No

**RELATIVE'S APPROXIMATE AGE AT TIME OF DEATH:**

List the cause of death for those who died prior to age 50:

Father: \_\_\_\_\_ Mother's father: \_\_\_\_\_ Father's father: \_\_\_\_\_  
Mother: \_\_\_\_\_ Mother's mother: \_\_\_\_\_ Father's mother: \_\_\_\_\_  
Any Sibling: \_\_\_\_\_

## FAMILY ILLNESSES:

Check any illnesses which have occurred in a blood related brother (b), sister (s), mother (m), father (f) or grandparent (g):

	WHO		WHO
<input type="checkbox"/> Alcoholism/Substance Abuse	_____	<input type="checkbox"/> Emotional/Mental Illness/Suicide	_____
<input type="checkbox"/> Alzheimer's/Dementia	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Cancer (Breast)	_____	<input type="checkbox"/> Heart attack prior to age 50	_____
<input type="checkbox"/> Cancer (Colon)	_____	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Cancer (Prostate)	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Cancer (other) _____	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> High Cholesterol	_____

Are there other family illnesses that we should know about? \_\_\_\_\_

## SOCIAL HISTORY

Occupation: \_\_\_\_\_

Marital Status:  Married  Single  Widowed  Divorced  Other \_\_\_\_\_

Who do you live with now? \_\_\_\_\_

Number of children and year of birth: # of Sons: \_\_\_\_\_ Year of Births: \_\_\_\_\_

# of Daughters: \_\_\_\_\_ Year of Births: \_\_\_\_\_

If you have minor children, do they live in your household:  Yes  No  not applicable

Do you wear seatbelts?  Yes  No

Do you travel extensively outside the US (other than vacations)?  Yes  No

What is your smoking status?  Never  Past  Current

a. Year Quit: \_\_\_\_\_

b. Number of years smoked: \_\_\_\_\_

c. Average number of packs/day: \_\_\_\_\_  Smokeless  Cigar  Pipe  Cigarettes

d. Would you like help to quit?  Yes  No

On average, how many alcoholic drinks (1 drink = 12 oz. beer, 10 oz. wine cooler, 5 oz. wine, 1.5 oz liquor) do you consume?  Non-drinker  1-2 per week  1-2 per day  3 or more per day  other \_\_\_\_\_

a. Do you drink every day?  Yes  No

b. Have you ever thought you had a problem with drinking?  Yes  No

Do you follow a special diet?  Yes  No If yes, what kind? \_\_\_\_\_

Indicate the number of days per week you participate in the following exercise:

<input type="checkbox"/> Walking _____	<input type="checkbox"/> Running _____	<input type="checkbox"/> Weight lifting _____
<input type="checkbox"/> Biking/exercise machine _____	<input type="checkbox"/> Swimming _____	<input type="checkbox"/> Aerobics _____
<input type="checkbox"/> Organized sports _____	<input type="checkbox"/> Other: _____	

Do you need help from your doctor for a problem related to physical, verbal or mental abuse?  Yes  No

Are you at risk for AIDS/HIV?  Yes  Unknown  No

(Homosexual, Bisexual, Multiple Sex Partners, Needle drug use other than insulin)

Any street drug use?  Yes  No If yes, substance? \_\_\_\_\_, how long? \_\_\_\_\_

Do you need help from your doctor for an issue related to drugs:  Yes  No

## LIFE STYLE AND HEALTH RISKS

### Men and Women of all ages:

- Have you had a tetanus/diphtheria shot within the last 10 years?  Yes  No  Unknown
- Have you had two Measles, Mumps, Rubella shots or the diseases as a child?  Yes  No  Unknown
- Have you had the following shots?
- Hepatitis A (Transmitted by food)  Yes  No
- Hepatitis B (Transmitted by body secretions)  Yes  No
- Have you had your cholesterol checked within the last 5 years?  Yes  No  Unknown
- Result: \_\_\_\_\_ Year: \_\_\_\_\_
- Do you take a daily aspirin?  Yes  No
- Do you wear your seat belt?  Always  Sometimes  Never
- Have you had chicken pox?  Yes  No

### Women only:

- Do you take calcium supplements?  Yes  No
- Have you had a Pap Smear within the past 2 years? M/Yr? \_\_\_\_\_  Yes  No
- Have you had an abnormal Pap Smear?  Yes  No
- Do you usually do self breast exams?  Yes  No
- Have you had a professional breast exam with in the last 3 years? M/Yr? \_\_\_\_\_  Yes  No
- If 40 or above, have you discussed mammography with your doctor?  Yes  No
- If 50 or above, have you had a mammogram within the last 2 years? M/Yr? \_\_\_\_\_  Yes  No
- Have you ever had a bone density? Year? \_\_\_\_\_  Yes  No
- What age did you start menstruating? \_\_\_\_\_
- When was your last menstrual period \_\_\_\_\_
- Have you ever gone more than 3 months without a period?  Yes  No
- When did you become menopausal?  not applicable  Yes  No
- Have you ever taken HRT? (hormone replacement therapy)  Yes  No
- Have you had any abnormal bleeding?  Yes  No

### Men only:

- When was your last prostate exam? (rectal exam) \_\_\_\_\_
- When was your last PSA test? Year \_\_\_\_\_ Do you know the result? \_\_\_\_\_
- Do you do a yearly testicular self-exam?  Yes  No
- Have you had any history of urinary problems?  Yes  No

### Men and Women over age 50 only:

- Have you had your stool checked for blood within the last year?  Yes  No
- When was your last colonoscopy? (Year) \_\_\_\_\_ Was anything seen (ie: polyps, etc.?) \_\_\_\_\_