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:

☐ Anemia	☐ Emotional/Mental Illnesses	☐ Kidney Disease
☐ Asthma	☐ Emphysema	☐ Kidney Stones
☐ Arthritis	☐ Epilepsy/seizures	☐ Liver Disease
☐ Bleeding/Blood Disorder	☐ Glaucoma	☐Osteoporosis
☐ Breast cancer	☐ Hay Fever	☐ Migraine Headaches
☐ Cancer(s) _____	☐ Heart Problems	☐ Stroke
☐ Cataracts	☐ Hepatitis/Jaundice	☐ Thyroid Disease
☐ Colitis	☐ High Blood Pressure	☐ Tuberculosis/TB
☐ Depression	☐ HIV/AIDS	☐ Ulcers
☐ Constipation	☐ Mononucleosis	☐ 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
☐ Alcoholism/Substance Abuse	_____	☐ Emotional/Mental Illness/Suicide	_____
☐ Alzheimer's/Dementia	_____	☐ High Blood Pressure	_____
☐ Cancer (Breast)	_____	☐ Heart attack prior to age 50	_____
☐ Cancer (Colon)	_____	☐ Osteoporosis	_____
☐ Cancer (Prostate)	_____	☐ Stroke	_____
☐ Cancer (other) _____	_____	☐ Tuberculosis	_____
☐ Diabetes	_____	☐ 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:

☐ Walking	_____	☐ Running	_____	☐ Weight lifting	_____
☐ Biking/exercise machine	_____	☐ Swimming	_____	☐ Aerobics	_____
☐ Organized sports	_____	☐ 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.?)_____