ADULT HEALTH HISTORY FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB**	

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Previous or referring doctor:		**Date of last physical exam:**	

Please list your current health concerns in order of importance:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:				
	☐ Tetanus		☐ Pneumonia	
	☐ Hepatitis		☐ Chickenpox	
	☐ Influenza		☐ MMR *Measles, Mumps, Rubella*	

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐	Yes	☐	No

Please turn to next page

	Are you satisfied with your diet? If no briefly explain.
	Water intake: (circle number of cups per day): 1 2 3 4 5 6 7 8 9 10
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Cola
	# of cups/cans per day?
Alcohol	Do you drink alcohol? If yes, what kind? ☐ Yes ☐ No
	How many drinks per week?
	Are you concerned about the amount you drink? ☐ Yes ☐ No
	Do you drive after drinking? ☐ Yes ☐ No
Tobacco	Do you use tobacco? ☐ Yes ☐ No
	☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day
	☐ # of years ☐ Or year quit
Drugs	Do you currently use recreational or street drugs? ☐ Yes ☐ No
	Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No
Sex	Are you sexually active? ☐ Yes ☐ No
	If yes, are you trying for a pregnancy? ☐ Yes ☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:
	Any discomfort with intercourse? ☐ Yes ☐ No
Other	Fears: ☐ Claustrophobia ☐ Heights ☐Thunder/Lightning ☐ Dark ☐ Flying ☐ Water ☐ Animals: Which ones? ________________________ ☐ Other: ____
	Sense of body temperature? ☐ Chilly ☐ Warm
	Favorite Book or Movie?

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			***Children***	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Do you have any blood relative who has had any of the following (check any that apply):

☐ Autism
☐ Arthritis
☐ Asthma
☐ Bipolar Disorder
☐ Tics
☐ Anemia
☐ Depression
☐ Tuberculosis
☐ Heart disease
☐ Gonorrhea
☐ Stroke
☐ High blood pressure
☐ Brain Tumors
☐ Schizophrenia
☐ Cancer
☐ Syphilis
☐ Seizures
☐ Sickle cells
☐ OCD
☐ Aneurysms

WOMAN ONLY

Question	Yes	No
Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam: ________________ Date of last mammogram: ________________		
Ever have abnormal mammogram?	☐ Yes	☐ No

MEN ONLY

Question	Yes	No
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

Check conditions YOU have or ever had in the past:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Sexually Transmitted disease
- ☐ Chemical Dependency
- ☐ Colitis
- ☐ Emphysema
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ IBS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Panic Attacks
- ☐ Pneumonia
- ☐ Psychiatric Care
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Cancer
- ☐ Whooping Cough
- ☐ Migraine Headaches

REVIEW OF SYSTEMS

CIRCLE symptoms you currently have or had in the LAST 12 MONTHS

General: Chills, Fever, weight loss, fatigue, cravings, weight gain, changes in appetite, trouble sleeping, cold hands/feet, night sweats, Poor memory, other:	**Cardiovascular:** Chest pain, high blood pressure, irregular heart beat, low blood pressure, poor circulation, swelling of ankles, varicose veins, difficulty breathing, other:
Skin: Bruise easily, eczema, psoriasis, hives, rash, itching, changes in moles, ulcerations, change in hair/skin texture, other:	**Musculoskeletal:** muscle weakness, muscle pain, back/neck pain, joint pain or swelling, injuries, numbness, other:
Eye, Ear, Nose, Throat: Bleeding gums, blurred vision, double vision, earache, ear discharge, hay-fever, hoarseness, loss of hearing, nosebleeds, ringing in ears, sinus problems, difficulty swallowing, cold sores, other:	**Gastrointestinal:** Poor appetite, bloating, constipation, diarrhea, bowel changes, vomiting, gas, hemorrhoids, indigestion, nausea, rectal bleeding, stomach pain, bad breath, belching, black stools, vomiting, vomiting blood, other:
Neurological: headache, dizziness, tremors, fainting, seizures, forgetfulness, nervousness or anxiety, numbness, other:	**Endocrine:** excessive thirst, excessive hunger, hormonal imbalances, heat/cold intolerance, other:
Genito-urinary: frequent urination, pain on urination, poor bladder control, kidney stones, wake up to urinate, blood in urine, other:	**Respiratory:** Persistent cough, shortness of breath, wheezing, coughing up blood, production of phlegm, difficulty breathing when lying down, tight chest, asthma, bronchitis, other:

LIFESTYLE HABITS:

What behaviors or habits do you engage in regularly that support your health?

What behaviors or habits do you engage in regularly that poorly affect your health?

What are some obstacles that are challenging the kind of lifestyle you would like to live?

What are your expectations for today's visit?

Any additional information you would like to add:

Thank you for your time and effort. We look forward to your visit.

List the prescribed medication / inhalers you are taking (including how much, how long, and how often)		
Name the Drug	Strength	Frequency Taken

List the over-the-counter medications, including vitamins and herbs		
Name the Drug	Strength	Frequency Taken

Allergies to medications or other	
Name the Drug / Substance	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

On a scale of 1-10, how would you rate your energy (10 being the highest)?

On a scale of 1-10, how would you rate your quality of sleep?

During sleep do you: ☐ Grind Teeth ☐ Perspire ☐Talk ☐ Snore ☐ Walk ☐ Have nightmares?

Are you currently in a happy, satisfying relationship with someone? (very, mostly, somewhat, not)

What do you do for work? Do you enjoy your work? (Yes / No)

Are you exposed to any hazardous substances? (Yes / No) If yes what?

Do you do any kind of physical activity? (Yes / No), if yes, what kind, how much & how often?

Do you have a religious or spiritual practice (Yes / No). If yes what?

What is your current weight? _______________ Height _______________ Weight 1 year ago? _______________

As an adult what has been your maximum _______________ and minimum weight _____________ (do not include pregnancy)

Diet			
	Are you dieting or on any dietary restriction?	☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?	☐ Yes	☐ No
	Which foods do you crave? ☐Sweet ☐Sour ☐Salty ☐Fats ☐Breads ☐Spicy ☐Bitter		