ADULT HEALTH HISTORY

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1. ALLERGIES: LIST ALLERGIES TO MEDICATIONS, LATEX, DYE, ETC.

1. _____ 2. _____ 3. _____

PLEASE INDICATE BELOW THE REACTION IT CAUSES:

1. _____ 2. _____ 3. _____

2. MEDICATIONS

LIST ALL CURRENT MEDICATIONS INCLUDING OVER-THE-COUNTER DRUGS, HERBS, SUPPLEMENTS.

NAME	STRENGTH	HOW OFTEN
1.		
2.		
3.		
4.		
5.		

NAME	STRENGTH	HOW OFTEN
1.		
2.		
3.		
4.		
5.		

3. PATIENT PAST MEDICAL HISTORY

CHECK ALL YOUR MEDICAL CONDITIONS

Alcohol Problem ❑ YES ❑ NO	Chronic Bronchitis/ Emphysema ❑ YES ❑ NO	High Cholesterol ❑ YES ❑ NO	Stroke ❑ YES ❑ NO
Drug Problem ❑ YES ❑ NO	Diabetes ❑ YES ❑ NO	Kidney Disease ❑ YES ❑ NO	Thyroid Disease ❑ YES ❑ NO
Anemia ❑ YES ❑ NO	Glaucoma ❑ YES ❑ NO	Mental Problems ❑ YES ❑ NO	Tuberculosis ❑ YES ❑ NO
Arthritis ❑ YES ❑ NO	Gout ❑ YES ❑ NO	Migraines ❑ YES ❑ NO	Stomach Problems ❑ YES ❑ NO
Asthma ❑ YES ❑ NO	Heart Disease ❑ YES ❑ NO	Seizures ❑ YES ❑ NO	Intestinal Problems: ❑ YES ❑ NO
Cancer ❑ YES ❑ NO	High Blood Pressure ❑ YES ❑ NO		OTHER:
If YES to cancer, where:			

4. SURGERIES

LIST ALL THE SURGERIES YOU EVER HAD

1.		Date:		5.		Date:		9.		Date:	
2.		Date:		6.		Date:		10.		Date:	
3.		Date:		7.		Date:		11.		Date:	
4.		Date:		8.		Date:		12.		Date:	

5. SOCIAL HISTORY

MARITAL STATUS: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

NUMBER OF CHILDREN: _____

OCCUPATION: _____

LAST GRADE COMPLETED: _____

HIGHEST DEGREE RECEIVED: _____

DO YOU HAVE EITHER OF THE FOLLOWING: ❑ Living Will ❑ Healthcare Power of Attorney

DO YOU DRINK ALCOHOL: ❑ Yes ❑ No

IF YES ABOVE: Amount per week: _____ Type: _____

DO YOU CURRENTLY SMOKE? ❑ Yes ❑ No

IF YES ABOVE: Packs per day: _____ # of years: _____

DID YOU EVER SMOKE? ❑ Yes ❑ No

IF YES ABOVE: When stopped: _____ Amount: _____

HAVE YOU EVER USED RECREATIONAL DRUGS? ❑ Yes ❑ No

IF YES ABOVE: Type: _____

PLEASE TURN THE PAGE AND COMPLETE THE BACK ▶

NAME _____ DATE OF BIRTH _____

REVIEWED BY _____ DATE FORM COMPLETED _____

6. FAMILY MEDICAL HISTORY

	AGE	NAME	DISEASES	IF DECEASED, CAUSE OF DEATH
Father				
Mother				
Brother(s)				
Sister(s)				
Children				
Spouse				

ANY FAMILY HISTORY OF:

Coronary artery disease (heart attack, angioplasty, heart surgery): ❑ Yes ❑ No Whom: _____

High blood pressure: ❑ Yes ❑ No Whom: _____

Diabetes (blood sugar): ❑ Yes ❑ No Whom: _____

Cancer: ❑ Yes ❑ No Whom and What type: _____

7. IMMUNIZATION HISTORY

PLEASE INDICATE THE MOST RECENT YEAR

Flu Vaccine (Date): _____ Pneumovax Vaccine (Date): _____

Last Tetanus (Date): _____ Hepatitis Vaccine (Date): _____

FOR PATIENTS WITH DIABETES ONLY:

Last visit to the podiatrist (Date): _____

Last visit to the ophthalmologist (Date): _____

8. PREVENTATIVE

Colon Cancer Screening ❑ Yes ❑ No

IF YES ABOVE: When _____; What type of screen test: _____

Date of last Bone Density Scan _____

MALES ONLY:

Date of last Rectal Exam _____

Date of last PSA Level _____

FEMALES ONLY:

Date of last Pap Smear/Pelvic Exam _____ Number of pregnancies _____

Date of last Mammogram _____ Number of miscarriages _____

Date of Last menstrual period _____ Birth control method _____

HOW DID YOU HEAR ABOUT US?

_____

NAME _____ DATE OF BIRTH _____

REVIEWED BY _____ DATE FORM COMPLETED _____