

Adult Health History (16 years or older)

Name: _____ DOB: _____ / _____ / _____ Sex M _____ F _____

Past Medical History (Check all items that apply to you and fill in blanks as needed.):

- | | |
|--|--|
| _____ Allergies | _____ Hepatitis A B C / Jaundice |
| _____ Anemia or blood problems | _____ HIV / AIDS |
| _____ Arthritis | _____ Hypertension |
| _____ Asthma | _____ Hypothyroid / Hyperthyroid |
| _____ Birth defects _____ | _____ Inherited disease |
| _____ Blood transfusion, year _____ | _____ Kidney disease / stones |
| _____ Cancer / tumor, explain _____ | _____ Mental illness / depression |
| _____ Chicken pox | _____ Pap smear abnormal |
| _____ Colon disease | _____ Peptic Ulcer Disease/GERD |
| _____ COPD, Emphysema, lung disease | _____ Sexually transmitted disease (STD) |
| _____ Diabetes type _____ how long _____ | _____ Sickle Cell Anemia / trait |
| _____ Drug / alcohol abuse | _____ Skin disease, eczema, psoriasis |
| _____ Epilepsy | _____ Stroke |
| _____ Hearing loss | _____ Other _____ |
| _____ Heart disease / attack | _____ |

Past Surgical / Hospitalization History:

- | | |
|------------------------------------|---|
| _____ Angioplasty | _____ Hernia R / L _____ |
| _____ Appendectomy | _____ Hysterectomy (uterus) |
| _____ Back procedure _____ | _____ Hysterectomy (ovaries) |
| _____ Breast procedure R / L _____ | _____ Knee R/L _____ |
| _____ Cervical freezing / LEEP | _____ Psychiatric treatment in/outpatient |
| _____ Fracture _____ | _____ Vasectomy |
| _____ Gallbladder | _____ Other _____ |

For office use only:	
_____	_____
Initials	Date

PATIENT NAME: _____

Last Lab work/Radiology:

Lipid / Cholesterol Panel _____ TSH _____ CBC _____
 Chest X-Ray _____ EKG _____
 Colonoscopy _____ Bone Density _____

Females Only:

Age at first period: _____ Birth Control Method: _____
 Number of: Pregnancies _____ Live births _____ Miscarriages _____ Abortions _____
 Date of last: Period _____ Pap smear _____ Mammogram _____

Males Only:

Last Physical Exam _____ Prostate Exam _____ PSA _____

Drug Allergies:

_____ No known drug allergies

Name of Drug	Reaction
_____	_____
_____	_____
_____	_____

Current Medications: *(please include all prescription, birth control pills, over the counter, herbs and vitamins)*

Medication Dose and Frequency	Medication Dose and Frequency
_____	_____
_____	_____
_____	_____

Immunizations / Injections: *(please put year of last injection)*

_____ Tetanus Booster _____ Hepatitis B _____ Other _____
 _____ Flu Vaccine _____ Hepatitis A
 _____ Pneumonia Vaccine _____ TB Skin Test

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PATIENT NAME: _____

Social History

Tobacco: Cigarettes / Chew / Snuff: How much per day: _____ for how long: _____

Alcohol: How many per day / week / month: _____

Caffeine: Number of cups of coffee per day / week / month: _____

Number of cups of tea per day / week / month: _____

Number of cups of soda per day / week / month: _____

Do you exercise? Yes / No How Often: _____

Are you sexually active? Yes / No New Partner in the last year? Yes / No

Are you a victim of abuse? Yes / No _____ Physical _____ Sexual _____ Mental _____ Verbal

Who is / was the abuser? _____

Do you use a seat belt? Yes / No

Have you been exposed to hazardous materials? _____

Have you served in the military service? What branch? _____

Are you on a special diet / vegetarian? _____

Do you travel to foreign countries? Where? _____

Family History

	Living Age	Healthy/Illness	Deceased Age	Healthy/Illness
Father:	_____	_____	_____	_____
Mother:	_____	_____	_____	_____
Father's Father:	_____	_____	_____	_____
Father's Mother:	_____	_____	_____	_____
Mother's Father:	_____	_____	_____	_____
Mother's Mother:	_____	_____	_____	_____

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_____	_____
Initials	Date

PATIENT NAME: _____

	Living		Deceased	
	Age	Healthy/Illness	Age	Healthy/Illness
Brothers:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Sisters:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Children:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Signature of Patient or Parent: _____ Date: ____/____/____

Provider Review Signature: _____ Date: ____/____/____

For office use only:	
_____	_____
Initials	Date