

Name

Date

Adult Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions better. This form will not be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. **Thank you!**

Main reason for today's visit: _____

Other concerns: _____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional

- Recent fevers/sweats
- Unexplained weight loss/gain
- Unexplained fatigue/weakness

Respiratory

- Cough/wheeze
- Coughing up blood

Skin

- Rash
- New or change in mole

Eyes

- Change in vision

Gastrointestinal

- Heartburn/reflux
- Blood or change in bowel movement
- Nausea/vomiting/diarrhea
- Pain in abdomen

Neurological

- Headaches
- Memory loss
- Fainting

Ears/Nose/Throat/Mouth

- Difficulty hearing/ringing in ears
- Hay fever/allergies/congestion
- Trouble swallowing

Genitourinary

- Painful/bloody urination
- Leaking urine
- Nighttime urination
- Discharge: penis or vagina
- Unusual vaginal bleeding
- Concern with sexual functions

Psychiatric

- Anxiety/stress
- Sleep problem

Cardiovascular

- Chest pains/discomfort
- Palpitations
- Short of breath with exertion

Blood/Lymphatic

- Unexplained lumps
- Easy bruising/bleeding

Breast

- Breast lump
- Nipple discharge

Musculoskeletal

- Muscle/joint pain
- Recent back pain

Endo

- Cold/heat intolerance
- Increase thirst/appetite

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? Yes No

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	Dose (e.g., mg/pill)	How many times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please place an X in the box that best describes your relationship to the listed health issues. Also check the box if an immediate family member is affected (parents, siblings or children)

<i>Past</i>	<i>Present</i>	<i>Never</i>	<i>Family History</i>	<i>Past</i>	<i>Present</i>	<i>Never</i>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Problems with alcohol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elevated Cholesterol or Triglycerides
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug Dependency
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV positive
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgical implants
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke or TIA
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

Please place an X in the appropriate box referring to symptoms you have experienced in the past 30 days

NO	YES		NO	YES	
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue or low vitality	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Change in weight	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with sleep	<input type="checkbox"/>	<input type="checkbox"/>	Pain between shoulders
<input type="checkbox"/>	<input type="checkbox"/>	Excessive stress	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain
<input type="checkbox"/>	<input type="checkbox"/>	Exercise regularly	<input type="checkbox"/>	<input type="checkbox"/>	Pain in buttocks or down leg
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with ears or hearing	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain, tightness or cramping
<input type="checkbox"/>	<input type="checkbox"/>	Problems with eyes or vision	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain or stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Dental or gum problems	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty walking
<input type="checkbox"/>	<input type="checkbox"/>	Sinus problem	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sitting
<input type="checkbox"/>	<input type="checkbox"/>	Problems with throat, swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty lying down
<input type="checkbox"/>	<input type="checkbox"/>	Coughing	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty standing
<input type="checkbox"/>	<input type="checkbox"/>	Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain or discomfort	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or seizures
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Pain all over
<input type="checkbox"/>	<input type="checkbox"/>	Swelling: hands, knees, ankles, etc.	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea or loose stools	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Problems at home, or with family
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion, heartburn or reflux	<input type="checkbox"/>	<input type="checkbox"/>	Problems at work
<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	Skin problems
<input type="checkbox"/>	<input type="checkbox"/>	Excess gas or bloating	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising or bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Fever, chills or night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Problems with urination	<input type="checkbox"/>	<input type="checkbox"/>	Intolerance to heat or cold
<input type="checkbox"/>	<input type="checkbox"/>	Sexual difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been treated by
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain, nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Breast discomfort, lump or discharge
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever fasted on water only?			

Other _____

Questions for women only:

<input type="checkbox"/>	<input type="checkbox"/>	Pelvic mass or pain?
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge, odor or discharge
<input type="checkbox"/>	<input type="checkbox"/>	Problems with menstruation

Date of last menstrual period _____

SOCIAL HISTORY

Tobacco Use

Cigarettes Never Quit Date _____
 Current Smoker: packs/day _____ # of yrs _____
 Other Tobacco: Pipe Cigar Snuff Chew
 Are you interested in quitting? No Yes

Alcohol Use

Do you drink alcohol? No Yes # drinks/week _____
 Is your alcohol use a concern for you or others? No Yes

Caffeine Intake None Coffee/tea/soda _____ cups/day

Drug Use

Do you use any recreational drugs? No Yes
 Have you ever used needles to inject drugs? No Yes

Sexual Activity

Sexually active: Yes No Not currently
 Current sex partner(s) is/are: male female
 Birth control method: _____ None needed
 Have you ever had any sexually transmitted diseases (STDs)?
 No Yes
 Are you interested in being screened for sexually transmitted diseases? No Yes

Please list all of your surgeries and hospitalizations. Include an approximate date

Date: _____	SURGERY OR HOSPITALIZATION _____	Date: _____	SURGERY OR HOSPITALIZATION _____
1. _____		5. _____	
2. _____		6. _____	
3. _____		7. _____	
4. _____		8. _____	

REVIEWED BY _____