Health History

ADULT (18 years and older)

Last Name:______________________ **First Name:**___________________ **DOB:** __________________

Past Medical History: (please mark any that apply and explain)

- ☐ Abdominal complaints
- ☐ Anxiety / Depression
- ☐ Arthritis / Joint pains / Back pain
- ☐ Asthma / COPD / Chronic cough
- ☐ Cancer (type:___________)
- ☐ Cholesterol
- ☐ Chronic pain
- ☐ Diabetes
- ☐ Gynecologic disorders
- ☐ Headaches / Migraines
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Stroke
- ☐ Thyroid

Explanation/Other:____

Past Surgeries/Hospitalizations: (please list any surgeries/hospitalizations, date, and reason)

Surgery / Hospitalization	Date	Reason
1.		
2.		
3.		
4.		
5.		

Medications: (please include over-the-counter, herbal supplements, vitamins, and birth control)

☐ No medications at all ☐ See attached medications list

Medication	Dose	How Often
1.		
2.		
3.		
4.		
5.		

Allergies: ☐ Drug/medication allergies (*please explain below*):

Explanation:____

____

____

- ☐ No known drug allergies
- ☐ Animals ☐ Food
- ☐ Environmental
- ☐ No allergies at all

Other providers involved in your care: (please include dental, therapists, acupuncture, specialists)

Name	Specialty	Reason / Last visit
1.		
2.		
3.		
4.		
5.		

Turn over for page 2.

Today's Date:___________________________

Review of Systems: (please check system(s) and circle the condition(s) that apply today)

- ☐ **Breasts**: Skin changes, mass, pain, discharge
- ☐ **Ears**: Hearing loss, ringing, pain, discharge
- ☐ **Eye**: Visual change, blurred vision, glasses
- ☐ **Endocrine**: Heat/cold intolerance, excessive sweating, frequent urination, excessive thirst, thyroid problems, diabetes
- ☐ **GI**: Stomach-ache, nausea, vomiting, diarrhea, constipation, blood in stool, hemorrhoids, hepatitis
- ☐ **General**: Fever, chills, weight change, weakness
- ☐ **Genital**: Discharge, STDs, sores, abnormal periods, pain with intercourse, impotence
- ☐ **Head**: Trauma, concussion, headache
- ☐ **Heart**: Chest pain, high BP, murmurs, palpitations, swelling, trouble lying flat
- ☐ **Hematologic**: Anemia, easy bruising, bleeding, transfusions
- ☐ **Lungs**: Short of breath, wheeze, cough, asthma, COPD
- ☐ **Mouth / Throat**: Sore, hoarseness, cavities
- ☐ **Muscles / Bones**: Weakness, pain, joint stiffness, arthritis, gout
- ☐ **Neuro**: Dizziness, loss of sensation, weakness, tremor, tingling, fainting
- ☐ **Nose**: Runny, bloody, sneezing, itchy
- ☐ **Psychiatric**: Depression, anxiety, tension, memory difficulty
- ☐ **Skin**: Rash, hair change, nail change, moles
- ☐ **Urine**: Painful, frequency, discharge, blood
- ☐ **Vessels**: Leg swelling, painful walking, varicose veins, history of blood clots

Explanation/Other:____

Family History: (please mark the illnesses/conditions that any members of your family may have/had)

	Diabetes	Heart Disease	High BP	Stroke	High Cholesterol	Depression/ Mental Illness	Thyroid	Cancer (type)	Other (list)
Mother ☐Alive ☐Deceased	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
Father ☐Alive ☐Deceased	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
Sibling(s) ☐Alive ☐Deceased	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	

Health Maintenance:

Have you ever had a colonoscopy? Yes No *If yes*, when was it? Date:____________________

Have you ever had a bone density? Yes No *If yes*, when was it? Date:____________________

Have you ever had a mammogram? Yes No N/A *If yes*, when was it? Date:______________

Date of last menstrual period:_________________N/A Date of last pap smear:_____________N/A

Social History:

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widow

Children: Y N # female/ages:_________________# male/ages:___________________

Tobacco: Y N ☐ Chew ☐ Smoke ☐ Never user ☐ Former user ☐ I want to quit
If yes, how much used per day:____________________________Year quit:__________

Alcohol: Y N *If yes*, how much per week:___________________Year quit:__________

Marijuana: Y N ☐ Edibles ☐ Smoke *If yes*, how much per week:_____________

Recreational/street drugs (including IV drugs): Y N ☐ Never user ☐ Former user ☐ I want to quit
If yes, which substances:_______________How much per week:__________________

Working: Y N *If yes*, Occupation:____________________Employer:_______________

Exercise: Y N If yes, Type:_________________________How often:______________