GUNNISON VALLEY FAMILY PHYSICIANS
CERTIFIED AMERICAN BOARD OF FAMILY PHYSICIANS

ADULT Health History
18 years and older

Patient Name:_____ **DOB:**_____ **Today's Date:**_____

Preferred Pharmacy: **City Market** **Clark's Pharmacy** **Walmart**

Past Medical History

Please list any past medical history below: (examples include asthma, diabetes, high cholesterol, etc.)

Diagnosis or condition	Date of diagnosis or onset
1.	
2.	
3.	
4.	

Surgical History / Hospitalizations:

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

Medication History (include over-the-counter, herbal supplements, and vitamins):

☐ No medications at all ☐ See attached medications list

Medication name	Dose	How often
1.		
2.		
3.		
4.		

Allergies: ☐ No allergies at all ☐ No known drug allergies

☐ Drug/medication allergies ☐ Food allergies ☐ Environmental allergies

Allergen	Reaction
1.	
2.	

Family History *(do you have any blood relatives with these problems—Mother/Father/Siblings?)*

Stroke (who and what age):_____

High blood pressure (who and what age):_____

Heart attack (who and what age):_____

Diabetes (who and what age):_____

Cancer (who and what age):_____

Other pertinent conditions (who and what age, list condition):_____

GUNNISON VALLEY FAMILY PHYSICIANS
CERTIFIED AMERICAN BOARD OF FAMILY PHYSICIANS

ADULT Health History
18 years and older

How many siblings do you have:_____#female/ages:_____#male/ages:_____

Social History

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

Children: ☐ Yes ☐ No *If yes,* #female/ages:_____#male/ages:_____

Sex: ☐ Female ☐ Male ☐ Other CO detectors in the home: ☐ Yes ☐ No

Diet is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Special diet (vegan, diabetic, gluten-free)

Caffeine intake: ☐ Yes ☐ No *If yes,* amount per day:_____

Pets in the home: ☐ Yes ☐ No *If yes,* what types_____

Guns in the home: ☐ Yes ☐ No Where stored: ☐ Inside ☐ Outside Locked: ☐ Yes ☐ No

Have you ever been threatened, injured, or abused by someone you know?: ☐ Yes ☐ No

Seatbelt use: ☐ Yes ☐ No Stairs in the home: ☐ Yes ☐ No

Bike helmet use: ☐ Always ☐ Only w/mountain or road bike or motorized ☐ Never

Exercise: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy Sports:_____

Tobacco: ☐ Never user ☐ Former user ☐ Current user type(s): ☐ Chew ☐ Smoke ☐ I want to quit
If used, how much per day?_____Year quit:_____

Marijuana: ☐ Never user ☐ Former user ☐ Current user type(s): ☐ Edible ☐ Smoke ☐ I want to quit
If used, how much per day?_____Year quit:_____

Alcohol: ☐ Yes ☐ No *If yes,* how much per week:_____Other substances: ☐ Yes ☐ No

Working: ☐ Yes ☐ No *If yes,* type of work:_____Employer:_____

Health Maintenance / Immunizations

Are you up to date with immunizations? ☐ Yes ☐ No ☐ Unknown

If no / unknown, would you like to discuss vaccines that are due today? ☐ Yes ☐ No

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/PSA? ☐ Yes ☐ No *If yes,* when was it? Date:_____

Have you ever had a PAP smear? ☐ Yes ☐ No ☐ N/A *If yes,* when was it? Date:_____

Physical limitations

Please list any physical limitations you have:_____

Other providers involved in your care: (include dentist, therapists, specialists, etc.)

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

Are there any other important things we should know about you?

_____