Name:_____Birth Date:_____Date:_____

**ADULT HEALTH HISTORY FORM**

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

**Name of your previous primary care provider(s):**_____

**REVIEW OF SYMPTOMS:** Please check any symptoms you have or have had in the past.

***Constitutional***
___Recent fevers/sweats
___Weight loss/gain
___Fatigue/weakness

***Eyes***
___Change in vision

***Ears/Nose/Throat/Mouth***
___Difficulty hearing
___Ringing in ears
___Nose bleed
___Trouble swallowing

***Cardiovascular***
___Chest pains/discomfort
___Palpitations
___Short of breath with exertion
___Heart murmur

***Breast***
___Breast lump
___Nipple discharge

***Respiratory***
___Cough/wheeze
___Coughing up blood
___Snoring

***Gastrointestinal***
___Nausea/vomiting
___Heartburn/reflux
___Pain in abdomen
___Gas/bloating
___Blood in stool
___Change in bowel habits
___Diarrhea/constipation
___Hemorrhoids

***Genitourinary***
___Painful/bloody urination
___Leaking urine
___Frequent nighttime urination
___Concern with sexual functions

***Musculoskeletal***
___Muscle/joint pain
___Swelling/stiffness of joints

**Skin**
___Rash
___New or change in mole

***Neurological***
___Headaches
___Memory changes
___Fainting
___Seizures
___Lightheadedness
___Disequilibrium

***Psychiatric***
___Anxiety
___Depression
___Sleep problem
___Trouble concentrating

***Blood/Lymphatic***
___Unexplained lumps
___Easy bruising/bleeding

***Endo***
___Cold/heat intolerance
___ Appetite changes

***Women only***
___Abnormal Pap smear
___Bleeding between periods
___Extreme menstrual pain
___Hot flashes
___Painful intercourse
___Vaginal discharge

***Men only***
___Difficulties with erection
___Difficulties with ejaculation
___Lump in testicles
___Penis discharge

**Women's reproductive history:**
___#pregnancies____#live births
___#miscarriages____#abortions

**In the past month, have you had little interest or pleasure in doing things, or felt down, or hopeless?**__Yes__No

**How would you rate your general health?**
___Excellent
___Good____Fair____Poor

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

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

**ALLERGIES OR REACTIONS TO MEDICATIONS**_____

_____

**HEALTH MAINTENANCE SCREENING TESTS:** Please provide the dates.

Lipid (cholesterol)_____
Women: Mammogram _____
Pap Smear_____
Men: PSA (prostate specific antigen) _____
Colonoscopy _____
Bone density test_____
Eye exam_____
Dental exam_____

**IMMUNIZATIONS:** Please provide the dates.

Tetanus (Td)_____MMR_____Varicella_____Meningitis_____HPV_____
Hepatitis B_____Pneumonia_____Shingles_____Influenza (flu)_____

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**PERSONAL MEDICAL HISTORY:** Please indicate whether you have had any of the following medical problems

___Heart disease_____
___Asthma/Lung disease_____
___High cholesterol_____
___Thyroid problem_____
___Kidney disease_____
___Cancer_____
___High blood pressure_____
___Diabetes_____
___Other_____

**SURGICAL HISTORY:** Please list all prior operations (with dates):

**FAMILY HISTORY:** Please indicate the current health status of your immediate family members:

Father_____
Mother_____
Siblings_____
Children_____

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

High cholesterol_____
High blood pressure_____
Heart disease_____
Stroke_____
Diabetes_____
Breast cancer_____
Colon cancer_____
Malignant melanoma_____
Osteoporosis_____
Depression_____
Alcoholism_____
Bleeding or clotting disorder_____
Other_____

**SOCIAL HISTORY:**

**Marital Status**_____
**Occupation**_____
**Tobacco Use**_____
___Cigarettes___ Pipe___Cigars___Smokeless tobacco
How much do you or did you smoke_____per day?
For how many years?_____
Did you quit?_____ When?_____
Do you wish to quit?___ Yes___No____Eventually
**Alcohol Use**_____
How much alcohol do you drink?_____
Is your alcohol using a concern for you or others?_____
**Recreational Drug Use**_____Yes ___No

**Sexual Activity**_____
Sexually active:___Yes___No___Not currently___Never
Current sex partner(s) is/are:___male___female
Birth control method:_____
Have you ever had any sexually transmitted diseases (STDs)?___Yes___No
**Caffeine Intake**___None___Coffee/tea/soda cups/day
**Diet**___Good___Fair___Poor
**Exercise**____Regularly___No
**Safety**_____
Do you use a bike helmet?___Yes___No___N/A
Do you use seatbelts consistently?___Yes___No
Is violence at home a concern for you?___Yes___No

**OTHER COMMENTS/CONCERNS:**

Patient Signature_____Date_____

Physician Signature_____Date_____

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