_______________________ _________

Name Date

Adult Health History for New Patients

Your answers on this form will help your health care provider obtain an accurate history of your medical concerns and conditions. We realize this form is long, it is meant to make the questioning quicker by listing out the major medical conditions to stimulate your memory. Please ***only check*** the information that applies to you or your family history. If you cannot remember specific dates, please provide your best estimation. Thank you for your time and cooperation.

In the last **2 weeks**, have you been bothered by: Little interest or pleasure in doing things? ☐No ☐Yes
Feeling down, depressed or hopeless? ☐No ☐Yes

Current issues to discuss:

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________

IMMUNIZATIONS: List the approximate ***year*** received. For children please provide their immunization records.

Tetanus (Td)______ With Pertussis (Tdap)______ Varicella (Chicken Pox) shot or illness______ Pneumovax______ HPV______

Influenza (flu shot)______ Hepatitis B_______ Hepatitis A______ MMR______ Meningitis______ Zostavax (shingles)_____

MEDICATIONS: Please list all prescriptions, over-the-counter, vitamins, supplements, herbs, or home remedies you take or use daily or on an as needed basis. You may use the back of this paper if you need more room to write.

Medication	Dose	How many times a day?	Reason you take it?

ALLERGIES: Medications, Foods, or Environmental and the type of reaction you experience. ☐**No known allergies**

____

____

HEALTH MAINTENANCE SCREENING TEST:

Lipid (cholesterol)	Date________________	Abnormal?	☐No	☐Yes
Colonoscopy or Sigmoidoscopy	Date________________	Abnormal?	☐No	☐Yes
EKG	Date________________	Abnormal?	☐No	☐Yes
Chest x-ray (AAA screening)	Date________________	Abnormal?	☐No	☐Yes

Men:

Prostate exam or PSA blood test	Date_______________	Abnormal?	☐No	☐Yes

Women:

Mammogram	Date_______________	Abnormal?	☐No	☐Yes
Pap Smear	Date_______________	Abnormal?	☐No	☐Yes
HPV- high or low risk	Date_______________			
Bone Density Test (Dexa Scan)	Date_______________	Abnormal?	☐No	☐Yes

PERSONAL MEDICAL HISTORY: Do you now have (currently) or have had (past) any of the following conditions? ☐ **NONE**

Condition	Current	Past
Alcohol/drug abuse		
Allergy (Hay Fever)		
Anemia		
Anxiety		
Arthritis		
Asthma		
Bipolar		
Bladder/Kidney Problems		
Blood Clot (leg)		
Blood Clot (lung)		
Blood Transfusion		
Cancer- Breast		
Cancer- Colon		
Cancer- Ovarian		
Cancer- Prostate		
Cancer- Other type		
Cataracts		
Chicken Pox		
Congestive Heart Failure		
Colon Polyp		
Depression		
Diabetes (child/adult onset)		
Diverticulosis		
Emphysema/COPD		
Fibromyalgia		
Fractures (broken bones		
Gallbladder Disease		
GERD/Heartburn		
Glaucoma		
Gout		
Gynecological (Endometriosis)		
Gynecological (Other)		
Heart Attack		
Heart Murmur		
Hemorrhoids		
Hepatitis A, B, C		
High Blood Pressure		
High Cholesterol		
Hip Fracture		
Irritable Bowel Syndrome		
Interstitial Cystitis		
Kidney Disease/Failure		
Kidney Stones		
Liver Disease		
Lupus		

SOCIAL HISTORY:

Tobacco Use-

Smoke cigarettes ☐Never ☐No ☐Yes
(If you never smoked, please go to alcohol use questions)

Quit date: _________ How many years did you smoke________

Approximately how many packs a day did you smoke? _______

Current smoker: Packs/day__________ # of years: ___________

Other tobacco: ☐Pipe ☐Cigars ☐Snuff ☐Chew

Alcohol Use-

Do you drink alcohol? ☐No ☐Yes

# of drinks per **week**?_________ ☐Beer ☐Wine ☐Liquor

Drug Use-

Do you use marijuana or recreational drugs? ☐No ☐Yes

If yes, which drugs? ____________________________________

Have you ever abused intravenous drugs? ☐No ☐Yes

Do you have a medical marijuana card? ☐No ☐Yes

SURGICAL HISTORY: Please check off any procedure or surgeries. List any abnormal findings or complications. ☐ **NONE**

Year: **Procedure:**

____
____
____
____
____
____
____
____
____
____

Migraine Headaches		
Osteoporosis		
Pneumonia		
Prostate (enlargement)		
Seizure/Epilepsy		
Skin Condition (Eczema)		
Skin Condition (Psoriasis)		
Skin Condition (Abnormal Mole)		
Sleep Apnea		
Stroke		
Thyroid-Hyperthyroidism (high)		
Thyroid- Hypothyroidism (low)		
Other- List		
Other- List		

FAMILY HISTORY:

Adopted- ☐**No** ☐**Yes** If yes and you **do not** know your family history skip this section and continue to social history.

Disease	Mother	Father	Sister (s)	Brother (s)	Mom-Parents	Dad -Parents
A- Alive **or D-** deceased						
No significant history known						
Alcoholism/Drug use						
Alzheimer's						
Asthma						
Autoimmune Disease						
Bleeding or Clotting Disorder						
Cancer- Breast						
Cancer- Ovarian						
Cancer- Other type						
Coronary Artery Disease (i.e. heart attack, angina, stents)						
Depression/Anxiety						
Suicide						
Diabetes						
Emphysema (COPD)						
Genetic Disorder (explain)						
High Blood Pressure						
High Cholesterol						
Thyroid (low or high)						
Kidney Disease or stones						
Migraine Headaches						
Osteoporosis						
Stroke						
Other not listed						

Social History:

Occupation (or prior occupation):_______________________________

☐Retired ☐Unemployed ☐Disabled ☐Leave of absence

Employer: ______________________ Years of education or highest degree: _____________________________________

Marital status: ☐Single ☐Partner ☐Married ☐Divorced ☐Widowed ☐Other____________________

Spouse/partner's name: _______________________ Number of children: ___________ Ages if under 18 years: _________________

Military Service: _______________________________ Exposure to chemicals or hazardous materials: _______________________

Leisure activities, group involvement, religion, volunteer work, recent travels out of the country.

____
____
____

WOMEN'S HEALTH HISTORY:

Total number of pregnancies? ________

Number of live births? _______

Number of abortions? ________

Miscarriages? _______

Ectopic pregnancy? __________

Date of last period: ______________

Age at beginning of periods? ______________

Age at end of periods? ____________

Hormone replacement? _______

Thank you for taking the time to fill this out.