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PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates)

___Heart disease: ___ High blood pressure ___High cholesterol
specify type _____ ___Diabetes ___Thyroid problem
___Asthma/Lung disease ___Other (specify) _____
___Kidney disease ___Cancer (specify) _____

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

_____

FAMILY HISTORY: Please indicate the current status of your immediate family members:
Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions.

Alcoholism_____
Cancer, specify type _____
Heart disease_____
Depression/suicide _____
Genetic disorders _____
Diabetes _____
High cholesterol _____
High blood pressure _____
Stroke _____
Bleeding or clotting disorder_____
Asthma/COPD _____
Other _____

Social History:

Tobacco Use
cups/day
Current smoker: Packs/day _____# of yrs. ____
Cigarettes __Never ___Are you interested in quitting? _____

Alcohol Use
Do you drink alcohol? ___No ___Yes #drinks/wk. ___
Is your alcohol use a concern for others? __No __ Yes

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? ____ Yes ____No
Are you interested in being screened for sexually transmitted diseases? ___ No ___ Yes

OTHER CONCERNS

Caffeine Intake: __ none __ Coffee/tea/soda _____

Weight: Are you satisfied with your weight? ____
Diet: How do you rate your diet? _ Good _ Poor
__

Do you eat or drink 4 servings of dairy or soy daily or take calcium supplements? __ No __ Yes
Exercise: Do you exercise regularly? __ No __ Yes
What kind of exercise? _____
How long (minutes) _____ How often? _____
If you do not exercise, why? _____
Safety: Do you use a bike helmet? ___ No ___Yes
Do you use seatbelts consistently? ___ No ___ Yes
Is violence at home a concern to you __ No __ Yes
Have you ever been abused? ____ No ___ Yes
Have you had a gun in your home? ___ No ___ Yes

Have you completed a living will or durable power of attorney for health care?___ No ___ Yes

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Please check all conditions you currently have or have had and describe complications:

General questions:	**Cardiovascular**	**Kidneys & Urinary Tract**	**Musculoskeletal**
Weight loss	Angina	Blood in urine	Anemia
Weight gain	Chest pain	Brown urine	Arthritis
Change in sleep patterns	Murmurs	Dribbling after urination	Back pain
Change in activity capacity	Leg cramps	Painful urination	Bursitis
Neurologic & Psychiatric:	Waking at night short of breath & getting out of bed.	Excessive thirst	Gout
Anxiety	Ankle swelling	Involuntary urination/incontinence	Joint aches
Headaches	Cardiac Catheterization	Frequent urination (day)	Abnormal blood counts
Depression	Cold hands or feet	Frequent urination (night)	Blood clots in legs/lungs
Meningitis	Congenital heart defects	Urinary hesitancy	Bone Marrow Biopsy
Paralysis	Dizziness when standing up quickly	Weak flow	Easy bleeding
Seizure	Heart attacks	Frequent bladder infections	Easy bruising
Stroke	Heart failure	Kidney disease	Joint swelling
Tingling	High or low blood pressure	Kidney stone	Morning stiffness
Tremors	Irregular heart beat	**Endocrine**	Muscle aches
Memory loss	Purple fingers or lips	Diabetes	**Gastrointestinal**
Fainting spells	Leg pain that resolves with rest	Sickle cell	Diarrhea
Dizziness	Heart palpitations	Abnormal body hair	Reflux
Head injuries	Varicose veins	Changes in skin texture	Gallstones
Black outs or near blackouts	**Respiratory**	Cold intolerance	Ulcers
Change in sensation anywhere in body	Pleurisy – Wheezing	Heat intolerance	Heartburn
Localized weakness or numbness	Asthma	History of “borderline” diabetes	Hepatitis
Ears, Eyes, Nose & Throat	Breathlessness when lying flat	Increased hair loss	Anal fissures
Hay fever	Prolonged cough	Rheumatism	Black tarry stools
Glaucoma	Coughing up blood	Thyroid disease	Vomiting blood
Polyps	Emphysema		Constipation

			Nausea
Allergy	Shortness of breath	**Male & Female**	Problems swallowing
Cataracts	Tuberculosis	Painful sexual intercourse	Hiatal hernia
Goiter	Pneumonia	Loss of sexual interest	Intestinal Obstruction
Hoarseness	Frequent infections (bronchitis)	Unprotected sex	Liver disease
Double vision	**Skin**	Groin itching	Hemorrhoids
Gum problems	Abscess	Sexually transmitted diseases	Red blood after bowel movements
Eye problems	Acne – Oily skin	**Males only**	**Females Only**
Ear infections	Dandruff	Hernia	D&C
Glasses/contacts	Boils – Rashes	Sterility	Hot flashes
Hearing loss	Hives	Bloody ejaculation	Hernia
Ear discharge/pain	Dry skin/Psoriasis	Inability to complete intercourse	Fibroids
Frequent nosebleeds	Jaundice	Lump on testicle	Abnormal bleeding between cycles
Ringing in your ears	Athlete's foot	Penile discharge	Complications with pregnancy
Sinus infections	Excessive body odor	Premature ejaculation	PMS - Endometriosis
Swollen glands	Excessive sweating	Problems maintaining or keeping an erection	Heavy bleeding during cycles
	Fungal infections	Prostate disease	Discharge from breast
	Nail problems	Sores on penis or warts	Ovarian cysts
	Moles – irregular	Testicular pain	Pelvic Inflammatory Disease
	Moles – change/new	Testicular swelling	Postmenopausal symptoms
			Vaginal discharge
			Vaginal dryness
			Vaginal warts

Provider notes:

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!

Age _____ How would you rate your general health? __ Excellent __ Good ___Fair ___ Poor

MAIN REASON FOR TODAY'S VISIT: _____

OTHER CONCERNS: _____

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

Constitutional ***Respiratory*** ***Skin***

__ Recent fevers/sweats	__Cough/wheeze	__Rash
__Unexplained weight loss/gain	__Coughing up blood	__New or change in mole
__Fatigue/weakness		

Eyes ***Gastrointestinal*** ***Neurological***

__Change in vision	__Heartburn/reflux	__Headaches
	__ Blood /change in bowel movement	__Memory loss
	__ Nausea/vomiting/diarrhea	__Fainting
	__ Pain in abdomen	

Ears/Nose/Throat/Mouth ***Genitourinary*** ***Psychiatric***

__Difficulty hearing/ringing in ears	__Painful/bloody urination	__ Anxiety
__Hay fever/allergies/congestion	__Leaking urine	__ Sleep problem
__ Trouble swallowing	__Nighttime urination	
	__ Discharge: penis or vagina	
	__ Unusual vaginal bleeding	
	__ Concern with sexual function	

Cardiovascular ***Musculoskeletal*** ***Blood***
Lymphatic

__Chest pains/discomfort	__ Muscle/joint pain	__ Unexplained lumps
__Palpitations	__Recent back pain	__ Easy bruising/bleeding

__Short of breath with exertion		

Breast ***Endo***

__ Breast lump	__ Cold/heat intolerance
__Nipple discharge	__Increase thirst/appetite

HAVE YOU RECENTLY HAD LITTLE INTEREST OR PLEASURE IN DOING THINGS, OR FELT DOWN, DEPRESSED OR HOPELESS?
___ YES ___ NO

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

Medication	**Dose (e.g., Mg. /pill)**	**How many times/day**

ALLERGIES OR REACTIONS TO MEDICATIONS:

_____

DATE OF YOUR MOST RECENT IMMUNIZATIONS:

Hepatitis A _____ Hepatitis B _____ Influenza (flu shot) _____ MMR _____ Pneumovax (pneumonia) _____

Meningitis _____ Tetanus (Td) _____ Varicella (chicken pox) shot or illness ____ Tdap (tetanus & pertussis) ____

HEALTH MAINTENANCE SCREENING TESTS:

LIPID (CHOLESTEROL) DATE: _____ ABNORMAL? __YES __NO
SIGMOIDOSCOPY OR COLONOSCOPY DATE: _____ ABNORMAL? __YES __NO

WOMEN: MAMMOGRAM DATE: _____ ABNORMAL? __YES __NO PAP SMEAR DATE: _____ ABNORMAL? __YES __NO
DEXASCAN (OSTEOPOROSIS) DATE: _____ ABNORMAL? __YES __NO

MEN: PSA (PROSTATE) DATE: _____ ABNORMAL? __YES __NO