Adult Health History Form

Name: _____ **DOB:**_____ **Date:**_____

Past Medical History: Please circle if YOU have now or have ever had any of these medical conditions

Allergies Anemia Anxiety Arthritis Cancer Coronary Artery Disease

COPD Congestive Heart Failure Depression Diabetes Enlarged Prostate Gallstones

GERD Headache-Migraines Heart Attack Heart Palpations High Cholesterol

Hypertension Hypothyriod Kidney Disease Obesity Osteoporosis Peptic Ulcer

Seizures Skin Cancer Stroke

Medication List

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies: Please List

_____ _____ _____ _____

Past Surgical History: Have you ever had surgery please list type surgery and date

_____ _____ _____

Hospitalizations: Please Circle if You have ever been hospitalized for any of these conditions

Asthma Congestive Heart Failure Coronary Artery Disease Diabetes COPD

Pneumonia Stroke Headache-Migraine Blood Clot

Family History Do you has a parent or sibling with a history of the following

		Relationship
Alcoholism	**Y N**	_____
Alzheimer's	**Y N**	_____
Anxiety	**Y N**	_____
ADD	**Y N**	_____
Asthma	**Y N**	_____
Breast Cancer	**Y N**	_____
Colon Cancer	**Y N**	_____
Heart Disease	**Y N**	_____
Diabetes	**Y N**	_____
Hepatitis C	**Y N**	_____
High Cholesterol	**Y N**	_____
High Blood Pressure	**Y N**	_____
Obesity	**Y N**	_____

Social History

Current Smoker? Y N If YES circle one below to indication how much you smoke

<10 cigarettes (1/2 pack/day) 10-20 cigarettes (1 pack/day) >20 cigarettes/day (2 pack/day)

Are you interested in quiting? Y N

Past Smoker? Y N If Yes, circle one below to indication how much

<10 cigarettes (1/2 pack/day) 10-20 cigarettes (1 pack/day) >20 cigarettes/day (2 pack/day)

How many years did you smoke?_____ Quit Date:_____

Sexual History:

Had sex in the past 12 months? Y N Use protection? Y N

Have you ever had a Sexually transmitted disease? Y N

Alcohol Use

How often did you have a drink containing alcohol in the past year?

• Never • Monthly or less • Two to four times a month • Two to three times per week
• Four or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?
• 1 or 2 • 3 or 4 • 5 or 6 • 7 to 9 • 10 or more

How often did you have six or more drinks on one occasion in the past year?
• Never • Less than monthly • Monthly • Weekly • Daily or almost daily

Are you a recovering alcoholic? Y N Quit Date? _____

Drug Use

How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?_____

Mood Questionare

1. Little interest or pleasure in doing things? Y N

2. Feeling down, depressed or hopeless? Y N

Domestic Violence

1. Within the past year, have you been hit, slapped, kicked, or physically hurt by someone? Y N

2. Are you in a relationship with someone who threatens or physically hurts you? Y N

3. Has anyone forced you to have sexual activities that made you feel uncomfortable? Y N

Preventive Exams and Test:

Last Colonoscopy:_____ Any history of an abnormal colonoscopy? Y N

Last EKG:_____ Any history of an abnormal EKG? Y N

Last Bone Density Scan (DEXA):_____ Any history of an abnormal DEXA? Y N

Women Only:

# of pregnancies_____ # of live births_____ Currently pregnant Y N

Birth Control method now_____ Age of 1st period_____ Age of menopause_____

Last pap smear_____ History of abnormal pap? Y N

Last mammogram_____ History of abnormal mammogram? Y N