Adult Health History

Name ______________________________ Date of Birth _____________ Today's date _________

Other health care providers ____

PRESENT HEALTH CONCERNS

Please list most important health concerns in order of their significance.	Prior diagnosis of this problem? If so, what?
1	
2	
3	
4	
5	

What goals do you have for your visit today? ____

____

List current prescription or over-the-counter medications, with dosages:_________________

____

____

____

List vitamins, herbs, and homeopathic remedies that you are taking, with dosages:_______

____

____

____

List any allergies to medications, environment and food.

SUBSTANCE SEVERITY/SYMPTOMS TREATMENT

____

____

____

Major hospitalizations, surgeries, injuries (please list all procedures, complications if any, and dates):

YEAR OPERATION, ILLNESS, INJURY OUTCOME

____

____

HEALTH SCREENING EXAMS List approximate date/year test was last performed.

Chest X Ray ___________ EKG ___________ Stress Test ___________ ECG _____________
Colonoscopy ___________ CT scan ___________ MRI ___________ Other ______________
WOMEN: PAP ____________Mammogram ____________ Pelvic Ultrasound _____________
MEN: Prostate exam ______________ PSA Blood test ______________

PERSONAL AND FAMILY HISTORY Check the "yes" box next to each condition that applies to you or one of your family members. Please note whether this applied to you or your family member in the past or currently.

	Yes	Who	Past or Current		Yes	Who	Past or Current
Alcoholism/ Drug Addiction				Heart Disease			
Allergies				Hepatitis			
Alzheimer's				High Blood Pressure			
Autoimmune Disorders				Kidney Disease			
Bleeding Disorders				Mental Health Problems			
Cancer				Migraines			
Colitis/ Crohn's				Osteoporosis			
Depression				Thyroid Problems			
Diabetes				Stroke			
Epilepsy				Other			

SOCIAL HISTORY

Marital Status: ❑single ❑married ❑divorced ❑widowed ❑separated ❑partner

Do you have children? ❑ YES ❑ NO Ages ____

Do you exercise? What kind/how often? ____

Do you sleep well? ____

What are your hobbies? ____

How is your energy level? _______________________ When do you feel best? ____________

Do you smoke/chew tobacco? ❑ YES ❑ NO How much? ______________________________

How much alcohol do you drink? ____

How much coffee/ black tea/ cola do you drink? __________________________________

Do you use recreational drugs? ❑ YES ❑ NO What and how often? __________________

Have you traveled outside the United States? _____________________________________

Please check any of the following that apply

GENERAL SYMPTOMS
_____ tired/no energy
_____ frequent colds/illnesses
_____ poor memory
_____ poor concentration
_____ headaches/migraines
_____ trouble sleeping
_____ night sweats
_____ alcohol dependence
_____ drug dependence
_____ eating disorder
_____ weight problem

SKIN & HAIR
_____ rashes/eczema
_____ hives/itching
_____ acne/boils
_____ dry/rough skin
_____ bruise easily
_____ nails weak/peel easily
_____ dry hair
_____ hair loss

EYES & EARS
_____ vision changes
_____ glaucoma
_____ cataract
_____ dry/itchy eyes
_____ sensitive to light
_____ circles under eyes
_____ earache/itch
_____ ear infections
_____ hearing problem
_____ ringing in ears

NOSE, MOUTH & THROAT
_____ recurring sinusitis
_____ runny nose/congestion
_____ post nasal drip
_____ nose bleeds
_____ sore throats
_____ canker sores
_____ cold sores
_____ bleeding gums
_____ toothache
_____ hoarse voice
_____ dry mouth
_____ poor taste/smell

LUNGS
_____ asthma
_____ wheezing
_____ cough frequently
_____ short of breath with activity
_____ short of breath lying down
_____ bronchitis/pneumonia history
_____ exposure to chemicals/fumes

HEART & CIRCULATION
_____ heart palpitation/racing
_____ heart murmur
_____ chest tightness/pressure
_____ dizzy or weak when stand up
_____ fainting
_____ high blood pressure
_____ heart attack/stroke
_____ swollen feet/ankles
_____ leg pains with walking
_____ loss of hair on legs
_____ varicose veins

DIGESTIVE TRACT
_____ loss of appetite or thirst
_____ difficulty swallowing
_____ nausea or vomiting
_____ don't tolerate fats/fatty food
_____ heartburn
_____ use antacids
_____ gas/burping/belching
_____ abdominal pain
_____ vomiting blood
_____ diarrhea or loose stools
_____ constipation
_____ dark stools or blood in stool
_____ mucous in stool
_____ undigested food in stool
_____ change in bowel pattern
_____ hemorrhoids
_____ anal itching/bleeding

URINARY
_____ urinate frequently
_____ pain with urination
_____ weak urine flow
_____ inability to hold urine
_____ change in urine color/odor
_____ kidney or bladder infections
_____ kidney stones

MUSCLES & JOINTS
_____ muscle pain
_____ painful/stiff joints
_____ loss of strength
_____ tremors/twitches cramps
_____ gout
Other ________________________

EMOTIONS
_____ anxiety/panic attacks
_____ anger issues/bad temper
_____ boredom
_____ depression
_____ mood swings
_____ relationship problems
_____ suicidal thoughts

ENDOCRINE
_____ thyroid problem
_____ heat or cold intolerance
_____ hypoglycemia
_____ excessive hunger
_____ excessive thirst
_____ easy weight gain
_____ unexplained weight loss
_____ chronic fatigue
_____ diabetes

MEN ONLY
_____ BPH
_____ diminished sex drive
_____ erectile dysfunction
_____ infertility
_____ hernia
_____ prostate cancer
_____ sexually transmitted infection
_____ swelling or pain in testes
Other ___________________________

WOMEN ONLY
Age of first period:_________________
Average # days for period:___________
Total days in cycle: ________________
Cycles regular? Y N
Age menses ceased: ________________
Birth control: ______________________
Number of pregnancies _____________
Number of children ________________
Do you have your uterus? Y N
Do you have your ovaries? Y N
History of abnormal PAP? Y N
Do you have:
_____ pain with or prior to periods
_____ bleeding between periods
_____ excessive flow
_____ difficulty conceiving
_____ ovarian cysts
_____ fibroids
_____ endometriosis
_____ abnormal vaginal discharge
_____ sexually transmitted infection
_____ painful intercourse
_____ diminished sexual desire
_____ hot flashes
_____ night sweats
_____ vaginal dryness
_____ breast tenderness/pain
_____ breast lump
_____ nipple discharge
_____ irritable/teary/moody