

## ADULT HEALTH HISTORY ( $\geq 17$ years old)

DATE: \_\_\_\_\_ NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ M F

This form is for background health information. It is part of your medical records and is strictly confidential. 2 PAGES TOTAL.

How may we communicate your results to you? (please circle)      MAIL      PHONE      FAX      ALL

Who Referred You? \_\_\_\_\_ Previous physician: \_\_\_\_\_

**Past Medical History**

Other doctors that you see? \_\_\_\_\_

Please check all that apply to you:

- |                                   |                              |
|-----------------------------------|------------------------------|
| Alcoholism _____                  | Heart Attack _____           |
| Allergies/ Hayfever _____         | (Other Heart Trouble) _____  |
| Anemia/ Bleeding _____            | Hepatitis _____              |
| Anorexia/ Bulemia _____           | High Blood Pressure _____    |
| Anxiety _____                     | High Cholesterol _____       |
| Arthritis/ Gout _____             | Kidney Disease _____         |
| Asthma _____                      | Liver Disease _____          |
| Birth Defects _____               | Mental Illness _____         |
| Blood Transfusion _____           | Pelvic Problem (women) _____ |
| Bowel Problems _____              | Prostate Problem (men) _____ |
| Cancer _____                      | Nerve Problem _____          |
| Circulation Problem _____         | Rheumatic Fever _____        |
| Depression _____                  | Stroke _____                 |
| Diabetes _____                    | Tattoos _____                |
| Emphysema/ COPD _____             | Thyroid Problem _____        |
| Epilepsy/ Seizures _____          | Tuberculosis (TB) _____      |
| Frequent Bladder Infections _____ | Ulcers in the Stomach _____  |
| Gall Stones _____                 | Venereal Disease/ STD _____  |
| Glaucoma _____                    | Other Problems _____         |
| Headaches _____                   | Type?: _____                 |

**Health Maintenance**

FEMALE:      # of Pregnancies? \_\_\_\_\_      # of Children? \_\_\_\_\_

Last Well-Woman Exam \_\_\_\_\_      Mammogram \_\_\_\_\_      Bone Density \_\_\_\_\_

MALE:      Last Physical Exam \_\_\_\_\_      Prostate Exam \_\_\_\_\_      PSA Blood Test \_\_\_\_\_

ALL:      Last Colonoscopy / Flexible Sigmoidoscopy \_\_\_\_\_      Stress Test \_\_\_\_\_      Tetanus \_\_\_\_\_      Pneumonia Shot \_\_\_\_\_

Do you have a LIVING WILL or ADVANCE DIRECTIVE ? \_\_\_\_\_      Would you like info ? \_\_\_\_\_

**Medications**      (Please list all medicines, with dosage, that you take REGULARLY. Include all pain-relievers, vitamins, supplements and herbs.)

- |    |    |    |    |     |
|----|----|----|----|-----|
| 1. | 3. | 5. | 7. | 9.  |
| 2. | 4. | 6. | 8. | 10. |

**Allergies**      (Please list any medication or food allergies and the reactions they cause you.)

- |    |    |    |
|----|----|----|
| 1. | 3. | 5. |
| 2. | 4. | 6. |

## ADULT HEALTH HISTORY

**Surgical History** (Please list all surgeries with approximate dates, including C-sections.)

- |    |    |    |    |
|----|----|----|----|
| 1. | 3. | 5. | 7. |
| 2. | 4. | 6. | 8. |

**Family History** (Please fill in your family's history, if known.)

	Age	Major health problems	Age at death	Cause of death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brother or Sister	_____	_____	_____	_____
Brother or Sister	_____	_____	_____	_____
Brother or Sister	_____	_____	_____	_____
Brother or Sister	_____	_____	_____	_____

**Social History**

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Marital Status M S D W

Children's names \_\_\_\_\_

Do you use tobacco? \_\_\_\_ If yes, please circle: Cigarettes Cigars Smokeless When did you quit? \_\_\_\_

Do you drink alcohol? \_\_\_\_ If yes, please circle: Beer Wine Liquor # of drinks per week \_\_\_\_

How many cups of coffee per day? \_\_\_\_ Tea? \_\_\_\_ Soda? \_\_\_\_

Do you use cocaine \_\_\_\_, marijuana \_\_\_\_, injected drugs \_\_\_\_, LSD (acid) \_\_\_\_, or speed \_\_\_\_?

What do you do for exercise?

**Review of Systems** (Please circle all symptoms that are a problem for you.)

- |       |                         |                     |                            |                         |            |                |
|-------|-------------------------|---------------------|----------------------------|-------------------------|------------|----------------|
| Const | fever                   | weight loss         | weight gain                | fatigue                 |            |                |
| HEENT | vision problem          | hearing problem     | dizziness                  | nose problem            | hoarseness | sore throat    |
| CV    | chest pain              | heart murmur        | palpitations/skipped beats | leg cramps when walking |            |                |
| Resp  | shortness of breath     | cough               | wheeze                     |                         |            |                |
| GI    | nausea/vomiting         | heart burn/reflux   | stomach pain               | constipation            | diarrhea   | blood in stool |
| GU    | problems urinating      | incontinence        | erectile dysfunction       | blood in urine          |            |                |
| MS    | joint pain              | muscle pain         | swelling                   | muscle cramps           | stiffness  |                |
| Skin  | skin problems           | hair problems       | nail problems              |                         |            |                |
| Neuro | headache                | numbness            | weakness                   | seizures                | tremor     |                |
| Psych | anxiety                 | depression          | hallucinations             |                         |            |                |
| Endo  | hot or cold intolerance | year of menopause ? |                            |                         |            |                |
| Heme  | bleeding problem        | easy bruising       | anemia                     |                         |            |                |
| Other | please describe:        |                     |                            |                         |            |                |

**Your Signature Here:**

**PLEASE STOP HERE**