

Med Rec # _____
Name _____
Birthdate _____ Age _____
Phone (H) _____ (W) _____
PCP _____

HEALTH HISTORY (ADULT)

Date _____ Referring physician _____

Occupation (past and present) _____

Reason for coming to the Clinic _____

Marital Status _____ Next of Kin _____ Phone # _____

PAST MEDICAL HISTORY: Have you had any of the following problems?

Medical Illnesses

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease or hepatitis | <input type="checkbox"/> Kidney disease/stones | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Acid reflux or hiatal hernia | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Migraine | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Cholesterol problem | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Environmental Allergies | Other _____ |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Blood clots or phlebitis | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Brain or nerve disease (stroke) | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Tuberculosis or abnormal skin test | |

Operations/Hospitalizations (include tonsillectomy and appendectomy)

Date	Operation/Hospitalization	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Severe Accidents and Injuries

Do you regularly wear seat belts? No Yes Do you regularly wear a helmet when bicycling or motorcycling? No Yes

Allergies and Adverse Medication Reactions (please list reaction)

Tobacco Use? No Yes Pkgs/day _____ # years _____ Quit? _____ Year Quit _____

Alcohol Use? No Yes Drinks/day _____ Drinks/week _____ Beer Wine Hard Liquor

Have you ever felt you should cut down on your drinking? No Yes

Have you ever been annoyed by people criticizing your drinking? No Yes

Recreational drugs: No Yes **IV drug user:** No Yes **Last HIV test?** _____

Female Patients

Last menstrual period _____ Last Pap smear _____ Last mammogram _____

Number of pregnancies _____ Number of births _____ Contraception _____

(check those you have experienced)

- Irregular periods Abnormal pap smear Painful periods Heavy periods

MEDICATIONS CURRENTLY TAKEN regularly or occasionally. include vitamins, birth control pills, sleeping pills, pain pills, laxatives, aspirin - with dosage

Glasses milk/day _____ Last osteoporosis scan _____ Calcium supplements (mg/day)? _____
Flu shot No Yes When _____ How often do you exercise? _____
Tetanus booster No Yes When _____ What is your workout? _____
Pneumonia vaccine No Yes When _____
Hepatitis B vaccine No Yes When _____ Last lower GI or lower scope? _____

FAMILY HISTORY

	Age of Death	Age if Alive	General health; major health problems & illnesses, OR age and cause of death
Mother			
Father			
Brothers			
Sisters			

Significant illness in Grandparents, Cousins, Aunts, Uncles or Children?

Remember, most diseases that "run in the family" are not genetic, but rather reflect lifestyle or behavior patterns that we learn in our families.

	NO	YES
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

REVIEW OF SYSTEMS: Do you have, or have you had **in the past month**, any of the following? (check those you have experienced)

General

- Recent fever
- Weight loss
- Night sweats
- Loss of energy
- Change in lymph nodes
- Snoring
- Trouble sleeping

Skin

- Rashes
- Changes in mole

Blood

- Easy bruising
- Excessive bleeding
- Transfusions

Ears

- Ringing
- Deafness

Eyes

- Cataracts
- Blind spots
- Double vision
- Trouble seeing
- When was last eye exam by eye DR? _____

Nose and Mouth

- Nosebleeds
- Tooth pain
- Sore throat
- Sinus pain
- Nasal congestion

Neck

- Goiter
- Difficulty swallowing

Breasts

- Discharge from nipples
- Lumps

Cardiovascular

- Chest pain
- Shortness of breath
- Leg swelling
- Heart murmur
- Palpitations
- Varicose veins

Pulmonary

- Wheezing
- Cough
- Pain when you breathe
- Excessive sputum
- Cough up blood

Digestive

- Poor appetite
- Gas or heartburn
- Nausea
- Vomiting
- Vomiting blood
- Abdominal pain or cramping
- Constipation
- Diarrhea
- Hemorrhoids
- Hernia
- Jaundice
- Rectal bleeding

Genitourinary

- Burning on urination
- Bloody urine
- Incontinence
- Infections
- Difficulty urinating
- Urination at night: # times _____
- Difficulty with erections
- Sexually transmitted diseases
- Multiple sexual partners

Skeletal

- Fractures
- Arthritis
- Leg pain when you walk
- Back or neck pain

Brain and Nerves

- Convulsions
- Dizziness
- Blackouts
- Weakness
- Stroke
- Headaches
- Depression, low motivation
- Numbness
- Anxiety, excessive worry

Is there anyone that you're afraid of?

Sources of Stress? _____

Do you have an Advanced Directive or end-of-life? _____