Adult Patient Health History

d.a.p.totalcare

The information completed on this questionnaire will become a confidential part of your medical record. If you do not want to answer a question, leave it blank and discuss it privately with your doctor at your visit.

Today's Date: _____ Appt. Date: _____ Previous Physician: _____

Name: _____ _____ _____ Date of Birth: _____
Last First Middle

ALLERGIES

Food ☐ Animals ☐ Latex ☐ Tape ☐ Pollens ☐ Eggs ☐ Iodine ☐ Nuts ☐

Other: _____

List Allergy Medications:

_____

MEDICAL HISTORY

MEDICATIONS

List all medications you are currently taking which have been ordered by a doctor (including inhalers) and all over-the-counter drugs, vitamins, or herbs. Please list prescribed medications first.

Your pharmacy name and location: _____ Phone: _____

Name of Medicine/Dose/Frequency:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ILLNESSES

Check major, significant illnesses which apply to you:

Anemia	☐	Emotional/Mental Illnesses	☐	Kidney Disease	☐
Asthma	☐	Emphysema	☐	Kidney Stones	☐
Arthritis	☐	Epilepsy/Seizures	☐	Liver Disease	☐
Bleeding/Blood Disorder	☐	Glaucoma	☐	Osteoporosis	☐
Breast cancer	☐	Hay Fever	☐	Migraine Headaches	☐
Cancer(s)	☐ _____	Heart Problems	☐	Stroke	☐
Cataracts	☐	Hepatitis/Jaundice	☐	Thyroid Disease	☐
Colitis	☐	High Blood Pressure	☐	Tuberculosis/TB	☐
Depression	☐	HIV/AIDS	☐	Ulcers	☐
Constipation	☐	Mononucleosis	☐	Gallbladder Disease	☐

Others: _____

SURGICAL

List the year of any operations/procedures you have had.

	Year		Year
Appendix Surgery	_____	Hip Surgery	_____
Breast Growth Removal	_____	Hysterectomy	_____
Carpal Tunnel	_____	Knee Surgery	_____
Cataract Removal	_____	Nasal/Sinus Surgery	_____
Cesarean Section	_____	Plastic Surgery	_____
Colonoscopy (looking into bowel)	_____	Polyp removal from intestine	_____
D&C	_____	Prostate Surgery	_____
Gallbladder surgery/laparoscopy	_____	Thyroid Surgery	_____
Gastroscopy (looking into stomach)	_____	Tonsils/Adenoids removed	_____
Heart catheterization/surgery	_____	Tubal Ligation	_____
Hernia	_____	Vasectomy	_____

Other: _____

TRAUMA/BROKEN BONES/SERIOUS ACCIDENTS

Trauma: _____ Year: _____
Trauma: _____ Year: _____
Trauma: _____ Year: _____

HOSPITALIZATIONS

List any other hospitalizations

Reason: _____ Year: _____
Reason: _____ Year: _____
Reason: _____ Year: _____
Reason: _____ Year: _____

OTHER PHYSICIANS

List any other doctors (specialists, etc.) you have seen.

_____
_____

FAMILY HISTORY

Are you adopted? Yes ☐ No ☐

List the cause of death for any relative who died prior to age 50.

Father: _____ Mother's Father: _____ Father's Father: _____
Mother: _____ Mother's Mother: _____ Father's Mother: _____
Any sibling: _____

FAMILY ILLNESSES

Check any illnesses which have occurred in a blood related brother, sister, mother, father, or grandparent

		Who?			Who?
Alcoholism/Substance Abuse	☐	_____	Emotional/Mental Illness/Suicide	☐	_____
Alzheimer's/Dementia	☐	_____	High Blood Pressure	☐	_____
Cancer - Breast	☐	_____	Heart Attack prior to age 50	☐	_____
Cancer - Prostate	☐	_____	Osteoporosis	☐	_____
Cancer - Colon	☐	_____	Stroke	☐	_____
Cancer - other _____	☐	_____	Tuberculosis	☐	_____
Diabetes	☐	_____	High Cholesterol	☐	_____

Any other family illnesses we should know about? _____

SOCIAL HISTORY

Occupation: _____
Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other ☐ _____
Who do you live with now? _____
Number of children & year of their birth? Son(s) _____ Year of birth(s) _____
Daughter(s) _____ Year of birth(s) _____
If you have minor children, do they live in your household: Yes ☐ No ☐
Do you wear seatbelts? Yes ☐ No ☐
Do you travel extensively outside of the US? Yes ☐ No ☐ Where? _____
What is your smoking status? Never ☐ Past ☐ Current ☐
Year quit? _____
Number of years smoked? _____ Smokeless ☐ Cigar ☐ Pipe ☐ Cigarettes ☐ Chew ☐
Average number of packs per day? _____
Would you like help to quit? Yes ☐ No ☐ N/A ☐

On average, how many alcoholic drinks do you consume? (1 drink=12 oz beer, 10 oz wine cooler, 5 oz wine, 1.5 oz liquor)
Non-drinker ☐ 1-2 per week ☐ 3 or more per day ☐ Other: ☐ _____
Do you drink every day? Yes ☐ No ☐
Have you ever thought you had a problem with drinking? Yes ☐ No ☐

Do you follow a special diet? Yes ☐ No ☐ If yes, what kind? _____

Indicate the number of days per week you participate in the following exercises:

Walking	_____	Running	_____	Weight Lifting	_____
Biking	_____	Swimming	_____	Aerobics	_____
Exercise Machine	_____	Organized Sports	_____	Other	_____

Do you need help from your doctor for a problem related to physical, verbal, or mental abuse? Yes ☐ No ☐

Are you at risk for HIV/AIDS? Yes ☐ No ☐ Unknown ☐

(Homosexual, Bisexual, Multiple sex partners, needle drug user (other than insulin))

Any street drug use? Yes ☐ No ☐ If yes, substance: _____ How long? _____

Do you need help from your doctor for an issue related to drugs? Yes ☐ No ☐

SEXUAL HISTORY

Are you currently sexually active? Yes ☐ No ☐

Have you had more than one partner in this last year? Yes ☐ No ☐ I have not had sex in the past year ☐

Do you have sex with:

Males Only ☐ Females Only ☐ Both ☐

What methods of birth control or protection do you currently use:

Condoms	☐	Oral contraceptives	☐
Implanon, IUD, Nuvaring	☐	Foam/spermicides	☐
Depo-Provera	☐	Rhythm method or withdrawal	☐
Nothing	☐	Other:	_____

Do you use condoms for:

Vaginal Sex ☐ Anal Sex ☐ Both ☐

How often to you use condoms during vaginal or anal sex?

Always ☐ Most of the time ☐ Sometimes ☐ Never ☐

Have you ever been told by a doctor or nurse that you had a sexually transmitted disease?

No ☐ Yes ☐ If yes, check all that apply:

Chlamydia	☐	Genital Herpes	☐	Trichomonas	☐
Gonorrhea	☐	Syphilis	☐	Other	_____
PID	☐	Genital Warts	☐	When was the last time you had one of these?	_____

Have any of your sexual partners:		Specify		
Had a sexually transmitted disease in the past year?	Yes ☐	_____	No ☐	I don't know ☐
Had other partners while still in a relationship with you?	Yes ☐	_____	No ☐	I don't know ☐
Had sex with prostitutes?	Yes ☐	_____	No ☐	I don't know ☐
Injected drugs?	Yes ☐	_____	No ☐	I don't know ☐

FOR MALES

Do you have any problems with sexual function?

Getting aroused?	Yes ☐	No ☐
Getting or maintaining an erection?	Yes ☐	No ☐
Problems with ejaculation or orgasm?	Yes ☐	No ☐

FOR FEMALES

Do you have any problems with sexual function?

Getting aroused?	Yes ☐	No ☐
Becoming lubricated?	Yes ☐	No ☐
Experiencing pain during sexual activity?	Yes ☐	No ☐
Problems with orgasm?	Yes ☐	No ☐

LIFESTYLE AND HEALTH RISKS

MEN & WOMEN OF ALL AGES

IMMUNIZATIONS

Flu (once annually) _____ Date last shot?

Pneumonia (once every 5 years) _____ Date last shot?

Tetanus _____ Date last shot?

Shingles (Zostavax) _____ Date last shot?

Have you had a tetanus/diphtheria shot within the last 10 years? Yes ☐ No ☐ Unknown ☐

Have you had two Measles, Rubella shots or the diseases as a child? Yes ☐ No ☐ Unknown ☐

Have you had the following shots?

Hepatitis A Yes ☐ No ☐

Hepatitis B Yes ☐ No ☐

HPV Yes ☐ No ☐

Have you had your cholesterol checked within the last 5 years? Yes ☐ No ☐

If so, result: _____ Year: _____

Do you take a daily aspirin? Yes ☐ No ☐

Have you had chicken pox? Yes ☐ No ☐

FOR FEMALES

Do you take calcium supplements? Yes ☐ No ☐

Have you had a Pap Smear within the past 2 years? Yes ☐ No ☐ Date: _____

Have you had an abnormal Pap Smear? Yes ☐ No ☐

Do you usually do a self-breast exam? Yes ☐ No ☐

When was your last mammogram? _____

Have you ever had a bone density performed? Yes ☐ No ☐

What age did you start menstruating? _____

When was your last menstrual cycle? _____

Have you ever gone more that 3 months without a period? Yes ☐ No ☐

Have you ever taken HRT? Yes ☐ No ☐

Have you had any abnormal bleeding? Yes ☐ No ☐

FOR MALES

When was your last prostate exam (rectal exam)? _____

When was your last PSA test? _____ Result: _____

Do you do a yearly testicular self-exam? Yes ☐ No ☐

Have you had any history of urinary problems? Yes ☐ No ☐

MEN & WOMEN OVER 50

Have you had your stool checked for blood within the last year? Yes ☐ No ☐

When was your last colonoscopy? Date: _____ Was anything found (polyps, etc.) Yes ☐ No ☐

If yes, what? _____

Additional comments: _____

Signature: _____ Date: _____