

# Adult Patient Health History



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

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	<input type="checkbox"/> _____	Emotional/Mental Illness/Suicide	<input type="checkbox"/> _____
Alzheimer's/Dementia	<input type="checkbox"/> _____	High Blood Pressure	<input type="checkbox"/> _____
Cancer - Breast	<input type="checkbox"/> _____	Heart Attack prior to age 50	<input type="checkbox"/> _____
Cancer - Prostate	<input type="checkbox"/> _____	Osteoporosis	<input type="checkbox"/> _____
Cancer - Colon	<input type="checkbox"/> _____	Stroke	<input type="checkbox"/> _____
Cancer - other _____	<input type="checkbox"/> _____	Tuberculosis	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____	High Cholesterol	<input type="checkbox"/> _____

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 <input type="checkbox"/>	Oral contraceptives <input type="checkbox"/>
Implanon, IUD, Nuvaring <input type="checkbox"/>	Foam/spermicides <input type="checkbox"/>
Depo-Provera <input type="checkbox"/>	Rhythm method or withdrawal <input type="checkbox"/>
Nothing <input type="checkbox"/>	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 <input type="checkbox"/>	Genital Herpes <input type="checkbox"/>	Trichomonas <input type="checkbox"/>
Gonorrhea <input type="checkbox"/>	Syphilis <input type="checkbox"/>	Other _____
PID <input type="checkbox"/>	Genital Warts <input type="checkbox"/>	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 <input type="checkbox"/>	_____	No <input type="checkbox"/>	I don't know <input type="checkbox"/>
Had other partners while still in a relationship with you?	Yes <input type="checkbox"/>	_____	No <input type="checkbox"/>	I don't know <input type="checkbox"/>
Had sex with prostitutes?	Yes <input type="checkbox"/>	_____	No <input type="checkbox"/>	I don't know <input type="checkbox"/>
Injected drugs?	Yes <input type="checkbox"/>	_____	No <input type="checkbox"/>	I don't know <input type="checkbox"/>

### 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 than 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: \_\_\_\_\_