**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 medical provider at your visit.

Today’s date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Appt date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Previous Provider: \_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Last First Middle

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| **ALLERGIES** |

□ Medications: List / Describe allergy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **MEDICAL HISTORY** |

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| **MEDICATIONS** |

List all medications you are currently taking which have been ordered by a provider (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:**

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
5. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 11. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
6. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 12. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IMMUNIZATIONS:**

**For Adults:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FLU (once annually)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pneumovax (once every 5 years)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prevnar (once)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tetanus (every 10 years)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shingles (Shingrix)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis A**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis B**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Meningococcus**

**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 □ Diabetes □ Ulcers

□ Constipation □ Mononucleosis □ Gallbladder Disease

□ HIV / AIDS (year of diagnosis - , lowest CD 4 count - , previous – Kaposi PCP Pneumonia Thrush )

Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SURGICAL HISTORY:**

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

Year Year

Colonoscopy (looking into bowel) \_\_\_\_\_\_\_\_\_ Polyp removal from intestine \_\_\_\_\_\_\_\_

Prostate Surgery \_\_\_\_\_\_\_\_ Appendix removal \_\_\_\_\_\_\_\_\_

Hip replacement \_\_\_\_\_\_\_\_ Knee replacement \_\_\_\_\_\_\_\_

Heart Catheterization \_\_\_\_\_\_\_\_ CABG Heart Bypass \_\_\_\_\_\_\_\_

Breast Growth Removal \_\_\_\_\_\_\_\_\_ Carpal Tunnel \_\_\_\_\_\_\_\_\_

Cataract Removal \_\_\_\_\_\_\_\_\_ Nasal/Sinus \_\_\_\_\_\_\_\_

Gallbladder surgery/laparoscopy \_\_\_\_\_\_\_\_\_ Thyroid \_\_\_\_\_\_\_\_

Gastroscopy (looking into stomach) \_\_\_\_\_\_\_\_\_ Tonsils/Adenoids removed \_\_\_\_\_\_\_\_

Hernia \_\_\_\_\_\_\_\_\_ Vasectomy \_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEN AND WOMEN OVER THE AGE OF 50 ONLY:**

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

When was your last colonoscopy? Year \_\_\_\_\_\_\_\_

Was anything seen (polyps, etc.)? □ Yes □No If Yes, what?\_\_\_\_\_\_\_

**HOSPITALIZATIONS:**

List any other hospitalizations

Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_

Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_

Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_

**TRAUMA / BROKEN BONES /SERIOUS ACCIDENTS:**

Trauma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_

Trauma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_

Trauma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_

**OTHER PHYSICIANS:**

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **FAMILY HISTORY** |

**ADOPTION:**

Are you adopted? □ Yes □ No

**RELATIVE’S APPROXIMATE AGE AT TIME OF DEATH:**

List the cause of death for those 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 (b), sister (s), mother (m), father (f), or grandparent (g):

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there other family illnesses that we should know about?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SOCIAL HISTORY** |

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: □ Married/Partnered □ Single □ Widowed □ Divorced □ Other

Who do you live with now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your smoking status? □ Never □ Past □ Current

1. Year Quit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Number of years smoked: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Average number of packs/day: \_\_\_\_\_\_\_\_\_ □Smokeless □ Cigar □ Pipe □Cigarettes □Chew
4. Would you like help to quit? □ Yes □ No

On average, how many alcoholic drinks (1 drink=12 oz. beer, 10 oz. wine cooler, 5 oz. wine, 1.5 oz. liquor) do you consume?

□ Non-drinker □ 1-2 per week □ 1-2 per day □ 3 or more per day □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

a. Do you drink every day? □Yes □ No

b. Have you ever thought you had a problem with drinking? □ Yes □ No

Do you follow a special diet? □ Yes □ No If YES, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you travel extensively outside the U.S. (other than vacations) □Yes □ No

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

□ Walking \_\_\_\_\_\_\_\_\_ □ Running \_\_\_\_\_\_\_\_\_\_ □ Weight Lifting \_\_\_\_\_\_\_\_\_\_\_

□ Biking/exercise machine \_\_\_\_\_\_\_\_\_ □ Swimming \_\_\_\_\_\_\_\_\_\_ □Aerobics \_\_\_\_\_\_\_\_\_\_\_

□ 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 AIDS / HIV? □ Yes □ No □ Unknown

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

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| **SEXUAL HISTORY** |

Are you currently sexually active?

□ Yes □ No

Have you had more than one partner in this last year?

□ Yes □ No, I have had one partner □ I have not had sex in the past year

Do you have sex with

□ Males only □ Females only □ Both

Do you use condoms for

□ Vaginal sex □ Anal sex □ Both

How often do 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 (check all that apply) □ Chlamydia □ Genital Herpes □ Genital Warts

□ Gonorrhea □ Syphilis □ Trichomonas

□ PID □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last time you had one of these diseases? \_\_\_\_\_\_\_\_\_month year\_\_\_\_\_

**Have any of your sexual partners**

Had a sexually transmitted disease in the past year? □ No □ I do not know □ Yes (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_

Had other partners while still in a relationship with you? □ No □ I do not know □ Yes

Had sex with prostitutes? □ No □ I do not know □ Yes

Injected drugs? □ No □ I do not know □ Yes

**For Males**

Do you have any problems with sexual functioning

□ Getting aroused

□ Getting or maintaining an erection

□ problems with ejaculation or orgasm

**For Females**

Do you have any problems with sexual functioning

□ Getting aroused

□ Becoming lubricated

□ Experiencing pain during sexual activity

□ Problems with orgasm

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| **Gender related HEALTH RISKS** |
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**MEN ONLY (including assigned male at birth):**

When was your last prostate exam (rectal exam)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last PSA test? Year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you know the result? Normal or High

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

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

**WOMEN ONLY: (including assigned female at birth):**

Have you had a Pap Smear within the past 3 years? When M/Y \_\_\_\_\_\_\_\_\_\_\_\_\_ □ Yes □ No

Where was the Pap performed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

If 40 or above, have you had mammogram within the last years M/Y \_\_\_\_\_\_\_ □ Yes □ No

Have you had a bone density performed after age 65? □ Yes □ No

When was your last menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you become menopausal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Not Applicable

Have you ever taken HRT? (Hormone Replacement Therapy) □Yes □ No

Have you had any abnormal bleeding? □ Yes □No

What method 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_