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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

ALLERGIES

□ Medications: List / Describe allergy:

_____

_____

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

Other: _____

MEDICAL HISTORY

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. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
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
□ Asthma
□ Arthritis
□ Emotional/Mental Illnesses
□ Emphysema
□ Epilepsy / Seizures
□ Kidney Disease
□ Kidney Stones
□ Liver Disease

□ Bleeding / Blood Disorder
□ Breast cancer
□ Cancer(s) _____
□ Cataracts
□ Colitis
□ Depression
□ Constipation
□ Glaucoma
□ Hay Fever
□ Heart Problems
□ Hepatitis / Jaundice
□ High Blood Pressure
□ Diabetes
□ Mononucleosis
□ Osteoporosis
□ Migraine Headaches
□ Stroke
□ Thyroid Disease
□ Tuberculosis / TB
□ Ulcers
□ Gallbladder Disease
□ HIV / AIDS (year of diagnosis - , lowest CD 4 count - , previous – Kaposi PCP Pneumonia Thrush)

Others: _____
_____

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?
_____
_____

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
a. Year Quit: _____
b. Number of years smoked: _____
c. Average number of packs/day: _____ □Smokeless □ Cigar □ Pipe □Cigarettes □Chew
d. 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

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

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 _____