ADULT HEALTH HISTORY

Name:

Date of birth:

Date: ____________________

History of Past Illness. At any point in time, have you had:

Childhood:

- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Rheumatic fever or heart disease
- ☐ Congenital Abnormalities

Adulthood:

- ☐ Blood Problems
- ☐ Breathing/lung problems
- ☐ High blood Pressure
- ☐ Cancer: Site _____________
- ☐ Diabetes
- ☐ Heart/Vascular disease
- ☐ Infections- Sexually Transmitted
- ☐ Joint pain
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Mental health problems
- ☐ Neurological problems
- ☐ Stomach/Bowel problems
- ☐ Thyroid Problems

Please list other additional illnesses or health problems. ____

Have you ever been seriously injured in an accident or knocked unconscious? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No

Have you ever been hospitalized or been under medical care for very long? ☐ Yes ☐ No

If yes, give reason: ____

Would you like to complete an Advance Directive form? ☐ Yes ☐ No

You may appoint a representative and give health care instructions for if you become unable to direct your care.

Allergies (medications, foods or other substances):

____

____

Medications (prescription, over the counter, vitamins and nutritional supplements):

Drug name	Dose	Drug name	Dose	Drug name	Dose

Operations:

Have you ever had any surgeries? ☐ Yes ☐ No

- ☐ Appendectomy
- ☐ Bypass, (if so, what): ____________________
- ☐ Gallbladder
- ☐ Hysterectomy
- ☐ Joint Surgery
- ☐ Ovaries Removed
- ☐ Other: ____________________

Pregnancy Information: G/PAL:

Year	Vaginal	C-section	Abort/miscarriage

Have you received these immunizations:

Flu Vaccine	☐ Yes	☐ No	Date Given:______________
Hepatitis A	☐ Yes	☐ No	Date Given:______________
Hepatitis B	☐ Yes	☐ No	Date Given:______________
Pneumovax	☐ Yes	☐ No	Date Given:______________
Tetanus	☐ Yes	☐ No	Date Given:______________
Other: ________________	☐ Yes	☐ No	Date Given:______________
Other: ________________	☐ Yes	☐ No	Date Given:______________

Health Maintenance:

When was your last..

Pap Smear ________ Breast Exam ________ Prostate Screen ________
Mammogram ________ Cholesterol Screen ________ Complete Physical ________
Colon cancer screen ________ Vision exam ________ Dental exam ________

Social History: Select one

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Significant Other ☐ Widowed

With whom do you live? ________

Are you sexually active? ☐ yes ☐ no With ☐ men ☐ women or ☐ both

Do you have any problems with sexual function? ☐ Yes ☐ No

Do you or your partner use birth control? ☐ Yes ☐ No If yes, what method? ________

Are you employed? ☐ Full-Time ☐ Part-Time ☐ None

What is your job? ________

Are you exposed to dust, fumes, or solvents? ☐ Yes ☐ No

If yes, please list known sources: ________

Are you in a relationship in which you have been physically hurt (i.e. slapped, kicked, punched, or threatened) by your partner? ☐ Yes ☐ No

Do you wear seatbelts? ☐ Always ☐ Sometimes ☐ Never

Education: Select as appropriate

High School: ☐ Graduate ☐ Non-Graduate ☐ GED

College: ☐ Graduate ☐ Non-Graduate ☐ None

Habits: Select as appropriate

☐ Coffee/Tea: # ________ per ________

☐ Soda: # ________ per ________

☐ Tobacco: # ________ per ________

☐ Drugs, please specify: ________

CAGE:

Do you drink alcohol? ☐ Yes ☐ No If so, how much? ________/week

Have you ever experimented with drugs? ☐ Yes ☐ No

In the last three months, have you felt you should cut down or stop drinking or using drugs? ☐ Yes ☐ No

In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs? ☐ Yes ☐ No

In the last three months, have you felt guilty or bad about how much you drink or use drugs? ☐ Yes ☐ No

In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs? ☐ Yes ☐ No

Diet & Exercise: How many servings do you get per day of the following:

☐ Vegetables & fruits ________ ☐ Meats, poultry, fish ________ ☐ Sweets & deserts ________
☐ Dairy products ________ ☐ Grains (bread, rice, creals) ________ ☐ Fats (oils, butter, cream) ________

Do you engage in any regular physical activity? ☐ yes ☐ no Please describe: ________

Family History:

	Father	Mother	Sibling	Grandparent	Spouse	Other	List Other
Bleeding Tendency	☐	☐	☐	☐	☐	☐	________
Cancer	☐	☐	☐	☐	☐	☐	
Types: ________							
Diabetes	☐	☐	☐	☐	☐	☐	________
Gout/Arthritis	☐	☐	☐	☐	☐	☐	________
Heart Trouble	☐	☐	☐	☐	☐	☐	________
Hereditary Defects	☐	☐	☐	☐	☐	☐	________
High Blood Pressure	☐	☐	☐	☐	☐	☐	________
Mental Illness	☐	☐	☐	☐	☐	☐	________
Stroke	☐	☐	☐	☐	☐	☐	________
Other: ________	☐	☐	☐	☐	☐	☐	________
Other: ________	☐	☐	☐	☐	☐	☐	________