Adult Health History

Name: _____

Date of birth: _____

Occupation: _____

Marital Status: _____

Any current or previous violence in your relationship or in your past_____

_____

Hobbies: _____

Do you smoke Y/N If yes, how much per day and for how long? If you previously smoked, when did you quit and how much/how long did you smoke for? _____

Alcohol: type and amount/week _____

Caffeine: type and amount/day _____

Street drugs: type and frequency _____

Weight: _____ Goal weight: _____

When was your last physical exam? _____

Please list all serious illnesses, operations, and other hospitalizations and when these occurred:

_____

_____

_____

_____

Describe any serious accidents, severe injuries, head injuries, fractures or broken bones (include dates occurred): _____

_____

_____

_____

Chief Complaints:

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing _____

_____

_____

_____

_____

_____

Past medical history

Have you ever had the following?

Measles Mumps Rubella	Heart Disease	Diabetes Type I Type 2
Chicken Pox	Arthritis Osteo Rheumatoid Other	Cancer: type
Shingles	Anemia	Heart Attack
Seizure Disorder Last Seizure	Headaches Migraines Tension Cluster	High cholesterol
Asthma	COPD	Other lung issues Specify
High blood pressure	Low blood pressure	Passing out
Irregular heartbeat	Atrial fibrillation	Bleeding or blood clotting disorder Type:
HIV/AIDS	Allergies Food Environment Animals Other	Stroke
Ulcers	Chronic constipation	Chronic Diarrhea
Colitis Crohn's	Other Stomach Issues Type:	Kidney Disease Type:
Thyroid disease Type:	Fibromyalgia	Chronic Fatigue
Autoimmune Disease Type:	Sleep Apnea Type:	Tuberculosis
Depression/anxiety	Substance Use/Dependence	Other Mental Health Type:
Back pain	Glaucoma	Osteoporosis
Liver disease	Gout	Other Disease Type:

Family History

List the health history of the family members below. If deceased, note the age and cause of death

Father
Mother
Brother(s)
Sister(s)
Children
Spouse
Grandparents

Symptoms

Do you have now or have had within the past 6 months:

Weakness or paralysis	Tire easily	Weight changes
Appetite changes	Sensitivity to cold or heat	Persistent fevers
Night sweats	Hot flashes	Rashes or skin problems
Changes in hair or nails	Headaches	Blurred or double vision
Do you wear glasses/contacts? Last eye exam?	Ringing in the ears	Hearing loss
Nose bleeds	Frequent colds	Sinus problems
Persistent hoarseness	Sore throat	Choking/swallowing issues
Breast lump or discharge	Chronic cough	Shortness of breath
Chest pain or discomfort	Purple fingers or toes	Swelling of hands, feet, or ankle
Palpitations or irregular heartbeat	Leg cramps	Heartburn or frequent belching
Abdominal pain	Nausea or vomiting	Chronic diarrhea
Chronic constipation	Rectal bleeding	Black tarry stools
Jaundice	Frequent urination	Increase in thirst
Painful urination	Leakage of urine	Difficulty starting urine
Lack of sex drive	Heavy bruising	Hemorrhoids
Back pain	Joint pain or stiffness	Swollen joints
Muscle cramps or spasm	Difficulty sleeping	Seizures
Memory loss	Poor concentration	Dizziness
Fainting	Anxiety	Depression
Men only: Discharge from penis Pain or lump in testicles Difficulty obtaining/maintaining erection	**Women only**: Do you have pain/cramps with your periods Moderate/severe mood changes before periods Do you still have your periods Pain with intercourse	Date of last mammogram _____ Date of last pap _____ Number of pregnancies _____ Number of births _____

Medications/Supplements

Medication/Supplement	Dose	Frequency

Allergies (medications, foods, environment)

note type and reaction
