# Adult Health History

West Erie Medical Group

Name _____ Birth Date ____/____/____ Gender M F
Last First M

Place of Employment _____ How Long? _____ Occupation _____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Highest Grade Completed _____

Do you have someone available to assist you in time of need? ☐ yes ☐ no

If married, spouse's name _____

Children's names and ages _____

Do you live alone? ☐ yes ☐ no Do you drive? ☐ yes ☐ no

Do you have any special spiritual or religious needs? ☐ yes ☐ no

Do you have any special cultural needs? ☐ yes ☐ no

Main language that you speak _____

Any ALLERGIES to medications, x-ray dyes, foods, or other substances? ☐ yes ☐ no If so, what type of reaction?

_____

_____

_____

## Past Medical History & Review of Systems

Please mark the box if you have had problems with or are presently complaining of any of the following:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Chest Pain/Discomfort
- ☐ Shortness of Breath
- ☐ Swollen Ankles
- ☐ Palpitations
- ☐ Light Headedness
- ☐ Frequent Urination
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Pneumonia
- ☐ Persistent Cough
- ☐ T.B.
- ☐ Hay Fever
- ☐ Abdominal Discomfort
- ☐ Indigestion
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Ulcers
- ☐ Change in Bowel Habits
- ☐ Hemorrhoids
- ☐ Gall Bladder Disease
- ☐ Colitis
- ☐ Hepatitis or Jaundice
- ☐ Thyroid Disease
- ☐ Head or Neck Radiation
- ☐ Headache
- ☐ Kidney Diseases
- ☐ Kidney Stones
- ☐ Difficulty Urinating
- ☐ Arthritis
- ☐ Low Back Problems
- ☐ Blood Disorders
- ☐ Venereal Diseases
- ☐ Anxiety
- ☐ Depression
- ☐ Anemia
- ☐ Alcohol Abuse
- ☐ Drug Abuse
- ☐ Gout
- ☐ Difficulty Eating
- ☐ Stroke
- ☐ Impotency
- ☐ Corrective Eyewear
- ☐ Bronchitis
- ☐ Unexplained Weight Gain/Loss
- ☐ Skin Diseases
- ☐ Hearing Difficulty
- ☐ Alzheimer's Disease

Any problems not listed above _____

| Level of Independence | Self | Need Assistance |
|---|---|---|
| Eating/Meal Preparation | | |
| Toileting | | |
| Walking | | |
| Bathing/Showering | | |
| Dressing | | |
| Household Tasks | | |

Are you on a special diet? ☐ yes ☐ no Type: _____

Have you had a change in eating habits in the last year? ☐ yes ☐ no

Do you use any community resources? (i.e. GECAC, Meals on Wheels, Home Health, etc.) ☐ yes ☐ no

## Gynecologic and Obstetric History

Age of onset of periods: _____ Frequency: _____ Length of Period: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Method of birth control: _____

Prolonged or abnormal bleeding: ☐ no ☐ yes (please describe) _____

Leakage of urine: ☐ no ☐ yes (please describe) _____

Pelvic Pain: ☐ no ☐ yes (please describe) _____

Abnormal discharge: ☐ no ☐ yes (please describe) _____

Please list and supply dates of:

Operations: _____

_____

Hospitalizations other than for surgery: _____

_____

Immunization history-have you had:

Hepatitis B? ☐yes ☐no When? _____

Other? ☐yes ☐no When? _____

Tetanus Immunization? ☐yes ☐no When? _____

Flu Immunization? ☐yes ☐no When? _____

Pneumovax Immunization? ☐yes ☐no When? _____

When was your last:

Pap Smear? _____ Breast Exam? _____ Stool check for blood? _____

Mammogram? _____ Cholesterol checks? _____ Prostate Exam? _____

**Family History** Has any member of your family (including parents, grandparents, and siblings) ever had the following? Please check and fill out appropriate boxes.

| Illness | Which family members? | Approximate age when diagnosed? |
|---|---|---|
| ☐ Cancer (describe type) | | |
| ☐ Hypertension (high blood pressure) | | |
| ☐ Heart Disease | | |
| ☐ Strokes | | |
| ☐ Mental Disease (anxiety, depression, etc.) | | |
| ☐ Drug or Alcohol Addiction | | |
| ☐ Diabetes | | |
| ☐ Glaucoma | | |
| ☐ Bleeding Ulcer | | |
| ☐ Other: _____ | | |

**Medications** (Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.)

| Drug Name | Dose | Drug Name | Dose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Prevention**

| | | | |
|---|---|---|---|
| Do you wear seatbelts? | ☐yes | ☐no | If no, why not? _____ |
| Do you wear a bike helmet? | ☐yes | ☐no | ☐N/A |
| Do you smoke? | ☐yes | ☐no | If yes, how many packs/day? _____ |
| Do you drink alcoholic beverages? | ☐yes | ☐no | If yes, how much/week? _____ |
| Do you drink coffee? | ☐yes | ☐no | If yes, how many cups/day? _____ |
| Do you drink tea? | ☐yes | ☐no | If yes, how many cups/day? _____ |
| If there is a gun in your home, is it out of children's reach and unloaded? | ☐yes | ☐no | ☐N/A |
| Do you use drugs? (marijuana, cocaine, crack, etc.) | ☐yes | ☐no | If yes, explain? _____ |
| Have you ever engaged in any activity which has you at risk of getting AIDS? | ☐yes | ☐no | |
| Do you wish to be tested for AIDS? | ☐yes | ☐no | |
| Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? | ☐yes | ☐no | If yes, explain? _____ |
| Are you in a relationship in which you have been physically hurt? (e.g. slapped, kicked, punched, bruised by your partner) | ☐yes | ☐no | |
| Do you ever feel afraid of your partner? | ☐yes | ☐no | |
| Do you have a "living will"? | ☐yes | ☐no | |
| Do you have a donor card? | ☐yes | ☐no | |

Parent/Guardian/Patient _____ Date _____

For Official Use Only: