

Adult Health History

Name _____ Birth Date ____/____/____ Male ____ Female ____
 Last First M

Place of Employment _____ How long? _____ Occupation _____

Full-time____ Part-Time____

Retired Unemployed Disability

If on disability, please give diagnosis for disability _____

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

What is the 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:

- | | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Venereal Diseases | <input type="checkbox"/> Unexplained weight gain/ loss |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> T. B. | <input type="checkbox"/> Colitis | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Skin Diseases |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Depression | <input type="checkbox"/> Hearing Difficulty |
| <input type="checkbox"/> Chest pain/discomfort | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Head/Neck Radiation | <input type="checkbox"/> Alcohol Abuse | |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Headache | <input type="checkbox"/> Drug Abuse | |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Gout | |
| <input type="checkbox"/> Light Headedness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Difficulty Eating | |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Impotency | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Low Back Problems | <input type="checkbox"/> Corrective Eyewear | <input type="checkbox"/> Change in Bowel Habits | |

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? no yes Type: _____

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

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

Gynecologic and Obstetric History

Do you see an OB/GYN? yes no

If you do see OB/GYN, please give name of provider _____

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) _____

History of abnormal pap smear no yes (please describe) _____

When was your last:

Pap smear? _____ Breast Exam? _____ Mammogram? _____

Please list and supply dates of:

Operations:

Hospitalizations other than for surgery:

Immunization history-have you had: Tetanus Immunization? yes no When? _____

Hepatitis B? yes no When? _____ Flu Immunization? yes no When? _____

Other? yes no When? _____ Pneumovax Immun.? yes no When? _____

When was your last:

Stool check for blood? _____

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?
<input type="checkbox"/> Cancer (describe type)	_____	_____
<input type="checkbox"/> Hypertension (high blood pressure)	_____	_____
<input type="checkbox"/> Heart Disease	_____	_____
<input type="checkbox"/> Strokes	_____	_____
<input type="checkbox"/> Mental Disease (anxiety, depression, etc.)	_____	_____
<input type="checkbox"/> Drug or Alcohol Addiction	_____	_____
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> Glaucoma	_____	_____
<input type="checkbox"/> Bleeding Ulcer	_____	_____
<input type="checkbox"/> Other: _____	_____	_____

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

Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Prevention

- Do you wear seat belts? 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? _____
- Have you ever smoked? yes no
- Do you use any form of tobacco? yes no
- 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 the reach of children 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 for 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 feel afraid of your partner? yes no
- Do you have a "living will"? yes no
- Do you have a donor card? yes no

If you are a diabetic, do you see an eye doctor? yes no
 If yes, please give name of eye doctor and date of last appointment _____

If you are a diabetic, do you see a foot doctor? yes no
 If yes, please give name of foot doctor and date of last appointment _____

Please list any specialists that you see for any reason:

Doctor: _____ Reason: _____

Doctor: _____ Reason: _____

Doctor: _____ Reason: _____

Parent/Guardian/Patient _____ Date ____/____/____