

**Health History for Adult Annual Exam**

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions.

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please update your contact information and pharmacy if they have changed since you were last seen:**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is the best way for us to contact you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Main reason for today’s visit:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What are your health goals for the next year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REVIEW OF SYMPTOMS:** Please mark the box and/or circle any **persistent** symptoms you have had in the **past few months**. Read through every section and check “no problems” if none of the symptoms apply to you. List other concerns above.

**General**

\_\_\_Chills

\_\_\_ Unexplained fatigue/ weakness

\_\_\_ Fever

\_\_\_ Unexplained weight loss/ gain

**\_\_\_** *No problems*

**Eyes**

\_\_\_ Change in vision/ eye pain/

redness

\_\_\_ Eye discharge

**\_\_\_** *No problems*

**Ears/Nose/Throat**

\_\_\_ Dental problems

\_\_\_ Ear pain / drainage

\_\_\_ Hearing loss / ringing in ears

\_\_\_ Sore throat / hoarseness

**\_\_\_** *No problems*

**Cardiovascular**

\_\_\_ Chest pain / discomfort

\_\_\_ Palpitations (fast or irregular

heartbeat)

**\_\_\_** *No problems*

**Respiratory**

\_\_\_ Cough / wheeze

\_\_\_ Loud snoring/ altered breathing

during sleep

\_\_\_ Short of breath with exertion **\_\_\_** *No problems*

**Gastrointestinal**

\_\_\_ Abdominal pain

\_\_\_ Blood or change in stools

\_\_\_ Heartburn / reflux / indigestion

\_\_\_ Constipation

**\_\_\_** *No problems*

**Genitourinary**

\_\_\_ Blood in urine

\_\_\_ Nighttime urination or

increased frequency

\_\_\_ Leaking urine

\_\_\_ Discharge: penis or vagina

\_\_\_ Concern with sexual function **\_\_\_** *No problems*

**Musculoskeletal**

\_\_\_ Back pain

\_\_\_ Muscle / joint pain

**\_\_\_** *No problems*

**Skin**

\_\_\_ New or change in mole

**\_\_\_** Rash / itching

**\_\_\_** *No problems*

**Breast**

\_\_\_ Breast lump / pain / nipple

discharge

**\_\_\_** *No problems*

**Neurological**

\_\_\_ Dizziness

\_\_\_ Fainting

\_\_\_ Frequent headache

\_\_\_ Dizziness

\_\_\_ Memory loss

\_\_\_ Numbness / tingling

\_\_\_ Unsteady gait

\_\_\_ Frequent falls

**\_\_\_** *No problems*

**Psychiatric**

\_\_\_ Depression

\_\_\_ Lack of concentration

\_\_\_ Nervousness / anxiety / stress

\_\_\_ Sleep problems

**\_\_\_** *No problems*

**Endocrine**

\_\_\_ Heat or cold sensitivity

**\_\_\_** *No problems*

**Hematologic/Lymphatic**

\_\_\_ Easy bruising

\_\_\_ Swollen glands

**\_\_\_** *No problems*

**Allergic/Immune**

\_\_\_ Seasonal allergies

\_\_\_ Food allergies

\_\_\_ Frequent infections

**\_\_\_** *No problems*

**Women only**

\_\_\_ Pre-menstrual symptoms

(bloating cramps, irritability)

\_\_\_ Problem with menstrual

periods

\_\_\_ Hot flashes / night sweats

**\_\_\_** *No problems*

**Other***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**IMMUNIZATIONS:** Did you receive any vaccines (Flu, Tetanus, etc.) somewhere else in the past year?

Vaccine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS:** Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc.

□ **TAKE NO MEDICATIONS**

Medication Dose (e.g. mg/pill) How many times per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you developed any allergies or intolerance to medications (include type of reaction): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH MAINTENANCE SCREENING TESTS OBTAINED *ELSEWHERE*:**

Lipid (cholesterol) Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Abnormal? □ No □ Yes

Sigmoidoscopy or Colonoscopy (circle one) Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Polyp? □ No □ Yes *Women only:*

Mammogram Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Abnormal? □ No □ Yes Pap Smear Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Abnormal? □ No □ Yes Bone Density Test Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Abnormal? □ No □ Yes

**OTHER HEALTH ISSUES:**

**Tobacco Use:**

Smoke cigarettes: □ Never □ Former □ Current

*(If you never smoked please go to alcohol use question now)*

Quit date: \_\_\_\_\_\_ How many years did you smoke? \_\_\_\_\_\_\_

Approximately how many packs a day did you smoke? \_\_\_\_\_\_\_

Current smoker: Packs/day: \_\_\_\_\_\_\_\_\_ # of years: \_\_\_\_\_\_\_\_\_

Other tobacco: □ Pipe □ Cigar □ Snuff □ Chew

**Alcohol Use**

Do you drink alcohol? □ No □ Yes

# of drinks/week: \_\_\_\_\_\_\_\_\_\_\_

**Drug Use**

Do you use marijuana or recreational drugs? □ No □ Yes

Have you ever used needles to inject drugs? □ No □ Yes

**Sexual Activity**

Sexually involved currently: □ No □ Yes

Sexual partner(s) is/are/have been: □ male □ female

Birth control method (circle below all that apply):

None Condom, pill, diaphragm, vasectomy, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exercise:**

Do you exercise regularly? □ Yes □ No

What kind of exercise\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long (minutes)? \_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_

**Diet:**

How would you rate your diet? □ Good □ Fair □ Poor

Would you like advice on your diet? □ No □ Yes

How many times in the past year did you fall?\_\_\_\_\_\_

Did you injure yourself in any fall? □ No □ Yes

Is violence at home a concern for you? □ No □ Yes

Have you completed an Advance Directive for Health Care (ADHC), Living Will, or POLST (Physician Orders for Life Sustaining Therapy)? (Circle above all that apply) □ Yes □ No

Please note any ***changes*** in your family medical history since your last visit:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Family History:** | **Age** | **Alive** | **Deceased/Cause of Death** | **Major Health Problems**  **(heart disease, stroke, cancer, diabetes, arthritis, etc)** |
| Father |  |  |  |  |
| Mother |  |  |  |  |
| Brothers |  |  |  |  |
| Sisters |  |  |  |  |
| Grandparents |  |  |  |  |
| Aunts/Uncles |  |  |  |  |
| Children |  |  |  |  |