

**Adult Health History for NEW Patients**

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please fill in all four pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

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

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

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

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

**Where were you getting your care before?**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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:** Check off any vaccinations you have had. Add year, if known.

Tetanus (Td) \_\_\_\_\_

With Pertussis (Tdap \_\_\_\_\_

Varicella (Chicken Pox) \_\_\_\_\_ (shot or illness)

Pneumovax (pneumonia) \_\_\_\_\_

Influenza (flu shot) \_\_\_\_\_

Hepatitis A \_\_\_\_\_

Hepatitis B \_\_\_\_\_

MMR \_\_\_\_\_

Meningitis \_\_\_\_\_

Zostavax (shingles) \_\_\_\_\_

HPV \_\_\_\_\_

**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. Use the back of this form if you need more room and let us know you wrote there.

□ **TAKE NO MEDICATIONS**

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

Allergies or intolerance to medications (include type of reaction): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ **NO ALLERGIES TO MEDICATIONS**

**HEALTH MAINTENANCE SCREENING TESTS:**

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

**PERSONAL MEDICAL HISTORY:** Please list any medical conditions that you have had. Include dates if possible:

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

**PERSONAL SURGICAL HISTORY:** Please list any surgeries that you have had. Include dates if possible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:**

Occupation (or prior occupation): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Retired/unemployed/leave of absence/disabled (circle one)

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years of education or highest degree: \_\_\_\_\_\_\_\_\_\_\_\_

Marital status (circle one): single, partner, married, divorced, widowed, other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/partner’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of children: \_\_\_\_\_\_\_ Ages if under 18 years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of grandchildren: \_\_\_\_\_\_\_\_\_\_\_\_\_ Number of great grandchildren: \_\_\_\_\_\_\_\_\_\_\_\_

Who lives at home with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Leisure activities, group involvement, religion, volunteer work, recent travel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WOMEN’S HEALTH HISTORY:**

Total number of pregnancies: \_\_\_\_\_\_\_ Number of births: \_\_\_\_\_\_\_\_

Date (month/day if known) of last menstrual period if you are still menstruating: \_\_\_\_\_\_\_\_\_\_\_\_

Age at beginning of periods (menstruation): \_\_\_\_\_\_\_\_\_

Age at end of periods (menopause): \_\_\_\_\_\_\_\_\_

**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

**Safety:**

Do you use a bike helmet? □ Yes □ No

Do you use seatbelts consistently? □ Yes □ No

Does your home have a working smoke detector? □ Yes □ No

If you have guns in your home, are they locked up? □ Not applicable □ Yes □ No

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

**Adopted? Y/N** □Family history unknown

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 |  |  |  |  |

Do you have any family history of heart disease, strokes, or sudden death below the age of 50? Yes\_\_ No\_\_