

**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 |  |  |  |  |