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## Adult Health History

Name \_\_\_\_\_ Date \_\_\_\_\_ Birth date \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ What is your reason for today's visit? \_\_\_\_\_

**Symptoms** check (✓) symptoms you currently have or have had in the past year.

**General**

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness or anxiety
- Numbness
- Sweats

**Muscle/Joint/Bone**

Pain, weakness or numbness in:

- Arms     Hips
- Hands    Feet
- Back     Legs
- Neck     Shoulders

**Genitourinary**

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

**Gastrointestinal**

- Appetite poor
- Bowel changes

- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

**Cardiovascular**

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

**Eye, Ear, Nose, Throat**

- Bleeding gums
- Blurred vision
- Cold sores
- Crossed eyes
- Difficulty swallowing
- Double vision

- Earache
- Ear Discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Photophobia
- Ringing in ears
- Sinus problems
- Eye infections
- Vision—flashes
- Vision—halos

**Skin**

- Bruise easily
- Eczema
- Hives
- Itching
- Change in moles
- Psoriasis
- Rash
- Scars
- Sore that won't heal

**Men only**

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge/sores

- Other

**Women only**

- Abnormal Pap smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other

Date of last menstrual period? \_\_\_\_\_

Date of last Pap smear? \_\_\_\_\_

Have you had a mammogram?  
 No  Yes

Are you pregnant?  No  Yes

What form of birth control do you use? \_\_\_\_\_

Number of pregnancies? \_\_\_\_\_

Number of children \_\_\_\_\_

**Conditions** check (✓) those you have or have had in the past

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Chickenpox       | <input type="checkbox"/> Irritable Bowel Disease | <input type="checkbox"/> Rheumatic fever              |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Colitis          | <input type="checkbox"/> Kidney disease          | <input type="checkbox"/> Scarlet fever                |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Liver disease           | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Anorexia            | <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Measles                 | <input type="checkbox"/> Suicide attempt              |
| <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Migraine headaches      | <input type="checkbox"/> Thyroid problems             |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Miscarriage             | <input type="checkbox"/> TMJ                          |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Goiter           | <input type="checkbox"/> Mononucleosis           | <input type="checkbox"/> Tonsillitis                  |
| <input type="checkbox"/> Bleeding disorders  | <input type="checkbox"/> Gonorrhea        | <input type="checkbox"/> Multiple Sclerosis      | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Breast lump         | <input type="checkbox"/> Gout             | <input type="checkbox"/> Mumps                   | <input type="checkbox"/> Typhoid Fever                |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Heart disease    | <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Ulcers                       |
| <input type="checkbox"/> Bulimia             | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Pneumonia               | <input type="checkbox"/> Vaginal infections           |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hernia           | <input type="checkbox"/> Polio                   | <input type="checkbox"/> Sexually transmitted illness |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Herpes           | <input type="checkbox"/> Prostate problem        | <input type="checkbox"/> Whooping cough               |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Psychiatric care        |   |

Medications and Supplements. List those you are currently taking.	Allergies to medications and substances.

Family History						
Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your <b>blood relatives</b> had any of the following and describe their relationship to you	
Father					<input type="checkbox"/> Aneurysm _____ <input type="checkbox"/> Headaches/Migraines _____ <input type="checkbox"/> Anxiety _____ <input type="checkbox"/> Heart disease _____ <input type="checkbox"/> Arthritis/Gout _____ <input type="checkbox"/> High blood pressure _____ <input type="checkbox"/> Asthma _____ <input type="checkbox"/> Kidney disease _____ <input type="checkbox"/> Autism _____ <input type="checkbox"/> Learning disabilities _____ <input type="checkbox"/> Bipolar Disorder _____ <input type="checkbox"/> Mental retardation _____ <input type="checkbox"/> Brain Tumors _____ <input type="checkbox"/> Muscular disease _____ <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Obsessive Compulsive DO _____ <input type="checkbox"/> Cerebral Palsy _____ <input type="checkbox"/> Schizophrenia _____ <input type="checkbox"/> Chemical dependency _____ <input type="checkbox"/> Syphilis _____ <input type="checkbox"/> Depression _____ <input type="checkbox"/> Tics _____ <input type="checkbox"/> Epilepsy/Seizures _____ <input type="checkbox"/> Tuberculosis _____ <input type="checkbox"/> Gonorrhea _____	
Mother						
Brothers						
Sisters						
<b>Health Habits</b> check (✓) which substances you use and describe how much you use.				<b>Occupational Concerns</b> check (✓) if your work exposes you to the following:		
	Caffeine					Stress
	Tobacco					Hazardous substances
	Alcohol					Heavy lifting
	Drugs				Other	
	Other					
<b>Exercise.</b> What kind of exercise do you do, and how often? _____						
Serious Illness/Injuries and Hospitalizations		Date	Outcome	Pregnancy History	Complications if any	
				Year/Date of birth		
<b>Preferences, Habits, and Particulars</b>						
Food			Sleep Habits			
Which foods do you crave? <input type="checkbox"/> Sweet <input type="checkbox"/> Sour <input type="checkbox"/> Salty <input type="checkbox"/> Fats <input type="checkbox"/> Breads Which foods do you hate? _____ Appetite? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor Thirst? <input type="checkbox"/> Very thirsty <input type="checkbox"/> Medium <input type="checkbox"/> Not at all			Bed time? _____ During sleep do you: Wake time? _____ <input type="checkbox"/> Grind teeth <input type="checkbox"/> Snore Time to fall asleep? _____ <input type="checkbox"/> Perspire <input type="checkbox"/> Walk Sleep position? _____ <input type="checkbox"/> Talk <input type="checkbox"/> Have nightmares? Do you recall your dreams? <input type="checkbox"/> Wake at night? Time _____ <input type="checkbox"/> Yes <input type="checkbox"/> No			
Fears			Temperature			
<input type="checkbox"/> Claustrophobia <input type="checkbox"/> Dark <input type="checkbox"/> Heights <input type="checkbox"/> Flying <input type="checkbox"/> Thunder/Lightning <input type="checkbox"/> Water <input type="checkbox"/> Animals. Which ones? _____ <input type="checkbox"/> Other _____			Sense of body temperature? <input type="checkbox"/> Chilly <input type="checkbox"/> Warm <input type="checkbox"/> Neutral Hands? <input type="checkbox"/> Chilly <input type="checkbox"/> Warm <input type="checkbox"/> Neutral Feet? <input type="checkbox"/> Chilly <input type="checkbox"/> Warm <input type="checkbox"/> Neutral			
Other						
Do you bite your nails? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Best time of day? _____ Worst time of day? _____			Favorite book or movie? _____			

Reviewed with patient \_\_\_\_\_