________________________________________
Name Date

________________________________________
Date of Birth

## Adult Health History for NEW Patients

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

Main reason for today's visit: ____________________________________________________

Other Concerns: __________________________________________________________

Where were you getting your care before? ____________________________________________

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

Tetanus _____________ With Pertussis (Tdap) ____________ Pneumovax (pneumonia) _____________

Influenza ___________ Zostavax (shingles) ______________

**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. Please continue onto the next page if you need more room.

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

**MEDICATIONS – CONTINUED:** 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):________________________________________
________________________________________________________________________ ☐ NONE

## 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:

Do you have now (current) or have you had (past) any of the following conditions? ☐ NONE

| Condition | | Current | Past | Comments |
|---|---|---|---|---|
| Alcohol/Drug Abuse | | | | |
| Allergy (Hay Fever) | | | | |
| Anemia | | | | |
| Anxiety | | | | |
| Arthritis (Rheumatoid) | | | | |
| Arthritis (Osteoarthritis) | | | | |
| Asthma | | | | |
| Bladder/Kidney Problems | | | | |
| Blood Clot (leg) | | | | |
| Blood Clot (lung) | | | | |
| Blood Transfusion | | | | |
| Breast Lump (benign) | | | | |
| Cancer Breast | | | | |
| Cancer Colon | | | | |
| Cancer Other Type | | | | |
| Cancer Ovarian | | | | |
| Cancer Prostate | | | | |
| Cataracts | | | | |
| Chicken Pox | | | | |
| Colon Polyp | | | | |
| Coronary Artery Disease | | | | |
| Depression | | | | |
| Diabetes (adult onset) | | | | |
| Diabetes (childhood onset) | | | | |
| Diverticulosis | | | | |
| Emphysema | | | | |
| Factures (broken bones) | | | | Where? |
| Gallbladder Disease | | | | |
| Gastroesophageal Reflux (Heartburn/GERD) | | | | |
| Glaucoma | | | | |

| PERSONAL MEDICAL HISTORY – Cont. | | Current | Past | Comments |
|---|---|---|---|---|
| Gout | | | | |
| Gynecological Conditions (Endometriosis) | | | | |
| Gynecological Conditions (Fibroids) | | | | |
| Gynecological Conditions (Other) | | | | |
| Heart Attack | | | | |
| Hepatitis – Type A | | | | |
| Hepatitis – Type B | | | | |
| Hepatitis – Type C | | | | |
| Hepatitis – Other | | | | |
| High Blood Pressure | | | | |
| High Cholesterol | | | | |
| Hip Fracture | | | | |
| Irritable Bowel Syndrome | | | | |
| Kidney Disease/Failure | | | | |
| Kidney Stones | | | | |
| Liver Disease | | | | |
| Migraine Headaches | | | | |
| Osteoporosis | | | | |
| Pneumonia | | | | |
| Prostate (enlargement) | | | | |
| Prostate (nodules) | | | | |
| Seizure / Epilepsy | | | | |
| Skin Condition (Eczema) | | | | |
| Skin Condition (Psoriasis) | | | | |
| Skin Condition (Abnormal Moles) | | | | |
| Sleep Apnea | | | | |
| Stomach Ulcer | | | | |
| Stroke | | | | |
| Thyroid (Nodule) | | | | |
| Thyroid High (Overactive) / Hyperthyroidism | | | | |
| Thyroid Low (Underactive) / Hypothyroidism | | | | |
| Other (list) | | | | |
| Other (list) | | | | |

**SURGICAL HISTORY:** Please check off any procedure or surgeries. List any abnormal findings or complications. ☐ NONE

| Surgical Procedure | | Yes | Year | Comments |
|---|---|---|---|---|
| Abdominal Surgery | | | | |
| Appendectomy (appendix removal) | | | | |
| Back Surgery (lumbar) | | | | |
| Biopsy (location) | | | | |
| Breast Biopsy | | | | Circle: Right Left Both |
| Breast Surgery | | | | Circle: Right Left Both |
| Colonoscopy | | | | |
| Coronary Bypass | | | | |
| Coronary Stent | | | | |
| EGD (Stomach Endoscopy) | | | | |
| Cataract | | | | |
| Gallbladder Removal | | | | Circle: Laparoscopic |
| Heart Surgery (other than coronary bypass) | | | | |
| Hip Surgery | | | | Circle: Right Left Both |
| Hysterectomy (total, including ovaries) | | | | Circle: Laparoscopic Vaginal Abdominal |
| Hysterectomy (partial, ovaries left) | | | | Circle: Laparoscopic Vaginal Abdominal |

| SURGICAL HISTORY – Cont. | | Yes | Year | Comments |
|---|---|---|---|---|
| Knee Surgery | | | | Circle: Right Left Both |
| LEEP (Cervix Surgery) | | | | |
| Neck Surgery | | | | |
| Ovary Ligation ("Tubal") | | | | |
| Ovary Removal | | | | Circle: Right Left Both |
| Vasectomy | | | | |
| Sigmoidscopy | | | | |
| Sinus Surgery | | | | |
| Other (list) | | | | |

**Adopted:** Yes No (Please Circle). If yes and you do not know your family history, skip this section and continue to page 5 (Other Health Issues)

**FAMILY HISTORY:** Indicate which relative has had the following diseases (parents and siblings are most important).

| Disease | Mother | Father | Sister(s) | Brother(s) | Mom's Mom | Mom's Dad | Dad's Mom | Dad's Dad | Other Relatives | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| No significant history known | | | | | | | | | | |
| Alcoholism / Drug Abuse | | | | | | | | | | |
| Alzheimer's | | | | | | | | | | |
| Asthma | | | | | | | | | | |
| Autoimmune Disease | | | | | | | | | | |
| Bleeding or Clotting Disorder | | | | | | | | | | |
| Cancer Breast | | | | | | | | | | |
| Cancer Colon | | | | | | | | | | |
| Cancer Other Type | | | | | | | | | | |
| Cancer Ovarian | | | | | | | | | | |
| Cancer Prostate | | | | | | | | | | |
| Colon Polyp | | | | | | | | | | |
| Coronary Artery Disease (e.g. heart attack, angina) | | | | | | | | | | |
| Depression/Suicide/Anxiety | | | | | | | | | | |
| Diabetes (childhood onset) | | | | | | | | | | |
| Diabetes (adult onset) | | | | | | | | | | |
| Emphysema (COPD) | | | | | | | | | | |
| Genetic Disorder (explain) | | | | | | | | | | |
| Glaucoma | | | | | | | | | | |
| Heart Disease (CHF) | | | | | | | | | | |
| Heart Disease (Other) | | | | | | | | | | |
| Hepatitis B or C | | | | | | | | | | |
| High Blood Pressure – Hypertension | | | | | | | | | | |
| High Cholesterol | | | | | | | | | | |
| Hip Fracture | | | | | | | | | | |
| Hypothyroidism / Thyroid Disease | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | |
| Kidney Stones | | | | | | | | | | |
| Macular Degeneration | | | | | | | | | | |
| Migraine Headaches | | | | | | | | | | |
| Osteoporosis | | | | | | | | | | |
| Other (list) | | | | | | | | | | |

## OTHER HEALTH ISSUES:

### Tobacco Use

Smoke cigarettes: ☐ Never ☐ No ☐ Yes
(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: ____________ ☐ Beer ☐ Wine ☐ Liquor

### 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 needed
Condom, pill, diaphragm, vasectomy, other___________________

### Exercise

Do you exercise regularly? ☐ No ☐ Yes
What kind of exercise? _______________________________
_____________________________________________

How long (minutes)? ___________ How often?______________

### Diet

How would you rate your diet? ☐ Good ☐ Fair ☐ Poor
Would you like advise on your diet? ☐ No ☐ Yes

### Safety:

Do you use a bike helmet? ☐ No bike ☐ No ☐ Yes
Do you use seatbelts consistently ☐ No ☐ Yes
Does your home have a working smoke detector? ☐ No ☐ Yes

If you have guns in your home, are they locked up?
☐ Not applicable ☐ 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)? ☐ No ☐ Yes
(*Circle above all that apply*)

## 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): ______________________________________________________

***Thank you for taking the time to fill this out.***