Adult Patient History and Health Assessment

Date:_____ **Patient Name:** _____ **DOB:**_____ **M / F**

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 that you wrote there.

☐ **I TAKE NO MEDICATIONS**

Medication	Dose (mg)	How Many Times Per Day

ALLERGIES: Please list all allergies or intolerance to medications. Please include type of reaction.

☐ **NO KNOWN ALLERGIES**

Allergies/Medication	Type of Reaction

PERSONAL MEDICAL HISTORY: Do you currently have or have had in the past any of the following conditions?

Illness	Month/Year	Illness	Month/Year
AIDS/HIV		Hepatitis Type:	
Anemia		High Blood Pressure	
Alcoholism		High Cholesterol	
Allergies		Kidney Disease	
Anorexia/Bulimia		Liver Disease	
Appendicitis		Lung Disease	
Arthritis		Measles	
Cancer		Migraine Headaches	
Chemical Dependency		Mononucleosis	
Chicken Pox		Pneumonia	
Depression		Psychiatric Care	
Diabetes		Rheumatic Fever	
Emphysema		Rubella	
Epilepsy		Sexually Transmitted Diseases	
Kidney/Bladder Infections		Stomach Ulcer	
Frequent Lung Infection		Stroke	
Gallbladder Disease		Thyroid Problems	
Gout		Tonsillitis	
Glaucoma/Eye Disease		Tuberculosis	
Heart Disease		Whooping Cough	

SURGICAL HISTORY:

Operation/Procedure	Date	Comments

OTHER SIGNIFICANT ILLNESSESS OR INJURIES:

Significant illness/injury	Date	Comments

PREVENTATIVE CARE: Please indicate the last time you had the following (MM/DD/YY if known).

Exam/Vaccine	Date	Exam/Vaccine	Date
Cholesterol Screening		Hepatitis Vaccine	
Eye Exam		TB Test	
Hearing Test		Tetanus Booster	
Stool Occult Blood Test		Flu Shot	

FAMILY HISTORY – Please indicate which relative has had the following diseases (Parents and siblings are the most important.)

√	Disease/Illness	Relationship (Father, Mother, Grandparents, Aunt/Uncles, Other)	Comments
	No Significant History Known		
	Aids or HIV		
	Alcoholism/Drug Abuse		
	Allergies		
	Anorexia/Bulimia		
	Arthritis		
	Asthma		
	Cancer		
	Bleeding or Clotting Disorder		
	Chicken Pox		
	Depression		
	Diabetes		
	Emphysema		
	Epilepsy		
	Kidney/Bladder infections		
	Frequent Lung Infection		
	Gallbladder Disease		
	Gout		
	Glaucoma/Eye Disease		
	Heart Disease		

	Hepatitis Type:		
	High Blood Pressure		
	High Cholesterol		
	Kidney Disease		
	Liver Disease		
	Lung Disease		
	Measles		
	Migraine Headaches		
	Mononucleosis		
	Mumps		
	Pneumonia		
	Psychiatric Care		
	Rheumatic Fever		
	Rubella		
	Sexually Transmitted Disease		
	Stomach Ulcer		
	Stroke		
	Thyroid Problems		
	Tonsillitis		
	Tuberculosis		
	Whooping Cough		

SOCIAL HISTORY:

TOBACCO USE:
Smoke cigarettes: [ ]NEVER [ ] NO [ ] YES
Other tobacco: [ ] Pipe [ ] Cigar [ ] Snuff [ ] Chew
Current Smoker: Packs/day_____ # of yrs:_____
Quit Date: _____
How many years did you smoke? ____
How many packs a day did you smoke?

ALCOHOL USE:
Do you drink alcohol? [ ] No [ ] Yes
# of drinks per wk: ___ [ ] Beer [ ] Wine [ ] Liquor

DRUG USE:
Do you use recreational drugs? [ ] No [ ] Yes
Use needles to inject drugs? [ ] No [ ] Yes

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____
Number of live births: _____
Date of Last Menstrual Period: _____
Age at beginning of periods:_____
Age at end of periods (menopause):_____
Current Birth Control: _____

Last Pap Smear: _____
Last Clinical Breast Exam: _____
Last Mammogram: _____

MEN'S HEALTH HISTORY:

Last Prostate Exam: _____ Results: _____
Last PSA: _____ Result: _____
Do you perform self exams every month? _____