Name Date

Adult Health History for NEW Patients

We know the form is long. Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update form you can use. Please fill in all five 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 and welcome to our clinic

Main reason for today's visit:_____

Other concerns: _____

What are your health goals for the next year? _____

Where were you getting your care before?_____

In the past 2 weeks, have you been bothered by: Little interest or pleasure in doing things? □ **No** □ Yes
Feeling down, depressed or hopeless? □ **No** □ **Yes**

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
- ☐ Unexplained weight loss / gain
- ☐ Unexplained fatigue / weakness
- ☐ Fall asleep during day when sitting
- ☐ Fever, chills
- ☐ No problems

Skin
- ☐ New or change in mole
- ☐ Rash / itching
- ☐ No problems

Breast
- ☐ Breast lump / pain / nipple discharge
- ☐ No problems

Ears/Nose/Throat
- ☐ Nosebleeds, trouble swallowing
- ☐ Frequent sore throat, hoarseness
- ☐ Hearing loss / ringing in ears
- ☐ No problems

Eyes
- ☐ Change in vision / eye pain / redness
- ☐ 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
- ☐ Heartburn / reflux / indigestion
- ☐ Blood or change in bowel movement
- ☐ Constipation
- ☐ No problems

Genitourinary
- ☐ Leaking urine
- ☐ Blood in urine
- ☐ Nighttime urination or increased frequency
- ☐ Discharge: penis or vagina
- ☐ Concern with sexual function
- ☐ No problems

Musculoskeletal
- ☐ Neck pain
- ☐ Back pain
- ☐ Muscle / joint pain _____
- ☐ No problems

Endocrine
- ☐ Heat or cold sensitivity
- ☐ No problems

Hematologic/Lymphatic
- ☐ Swollen glands
- ☐ Easy bruising
- ☐ No problems

Neurological
- ☐ Headache
- ☐ Memory loss
- ☐ Fainting
- ☐ Dizziness
- ☐ Numbness / tingling
- ☐ Unsteady gait
- ☐ Frequent falls
- ☐ No problems

Allergic/Immune
- ☐ Hay fever / allergies
- ☐ Frequent infections
- ☐ No problems

Psychiatric
- ☐ Anxiety / stress / irritability
- ☐ Sleep problem
- ☐ Lack of concentration
- ☐ No problems

Women only
- ☐ Pre-menstrual symptoms (bloating cramps, irritability)
- ☐ Problem with menstrual periods
- ☐ Hot flashes / night sweats
- ☐ No problems

IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information. □

Tetanus (Td)_____With Pertussis (Tdap)_Varicella (Chicken Pox) shot *or* illness_____Pneumovax (pneumonia) _____

Influenza (flu shot)_____Hepatitis A_____Hepatitis B_____MMR_____Meningitis_____Zostavax/Shingrix(shingles)_____

HPV_____FSME_____

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: □ NONE _____

HEALTH MAINTENANCE SCREENING TESTS:

□ NONE

Lipid (cholesterol)	Date _____	Abnormal?	□ No	□ Yes
Sigmoidoscopy or Colonoscopy (circle one)	Date _____	Polyp?	□ No	□ Yes
PSA	Date_____	Abnormal?	□ No	□ Yes
Mammogram	Date _____	Abnormal?	□ No	□ Yes
Pap Smear	Date _____	Abnormal?	□ No	□ Yes
Bone Density Test	Date _____	Abnormal?	□ No	□ Yes

PERSONAL MEDICAL HISTORY: What medical conditions are you now or were you in the past treated for?

□ NONE

Condition	Date of Condition	Condition	Date of Condition

SURGICAL HISTORY – What surgeries or other invasive procedures have you had? □ **NONE**

Surgical Procedure	*Year*	*Comments*
Appendectomy (appendix removal		
Back Surgery		
Biopsy (location		
Coronary Bypass		
Coronary Stent		

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 Relative	Comments
No significant history known	☐	☐	☐	☐	☐	☐	☐	☐		
Alcoholism / Drug abuse	☐	☐	☐	☐	☐	☐	☐	☐		
Alzheimers	☐	☐	☐	☐	☐	☐	☐	☐		
Asthma	☐	☐	☐	☐	☐	☐	☐	☐		
Autoimmune Disease	☐	☐	☐	☐	☐	☐	☐	☐		
Bleeding or Clotting Disorder	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer *Specify	☐	☐	☐	☐	☐	☐	☐	☐		
Coronary Artery Disease (e.g. heart attack, angina)	☐	☐	☐	☐	☐	☐	☐	☐		
Depression / Suicide / Anxiety	☐	☐	☐	☐	☐	☐	☐	☐		
Diabetes (childhood onset)	☐	☐	☐	☐	☐	☐	☐	☐		
Diabetes (adult onset)	☐	☐	☐	☐	☐	☐	☐	☐		
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐		
High Blood Pressure - Hypertension	☐	☐	☐	☐	☐	☐	☐	☐		
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐		
Hypothyroidism / Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐		
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐		
Kidney Stones	☐	☐	☐	☐	☐	☐	☐	☐		
Migraine Headaches	☐	☐	☐	☐	☐	☐	☐	☐		
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐		
Other (list)	☐	☐	☐	☐	☐	☐	☐	☐		

OTHER HEALTH ISSUES:

This helps us address areas that may be of concern to you or may impact your health.

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? □ 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

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

SOCIAL HISTORY:

This Helps us get to know you and the stressors/support you have in your life.

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:

Number of births: _____

Total number of pregnancies: _____

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): _____

Whew, you are done!

Thank-you fo taking the time to fill this out .