ADULT HEALTH HISTORY FORM

Name: _____

Date of birth: _____ **Date:**_____

PERSONAL MEDICAL HISTORY: (Check all that apply)

	Allergies		Diabetes		Hypothyroid
	Anemia		Enlarged Prostate		Lung Cancer
	Arthritis		Fractures		Obesity
	Asthma		Gallstones		Osteoporosis
	Blood clots		GERD		Pancreatitis
	Cancer-type _____		Graves' disease		Peptic Ulcer Disease
	Carotid Artery Blockage		Headache-Migraines		Prostate Cancer
	Colon Cancer		Heart Attack		Seizures
	Coronary Artery Disease		Heart Palpatations		Skin Cancer
	Congestive Heart Failure		Hepatitis		STD's
	COPD		High Cholesterol		Stroke
	Depression		Hypertension		Urinary Tract Infections- Frequent

FAMILY MEDICAL HISTORY: (Check all that apply for immediate family)

__Adopted __ Unknown

	Allergies		Heart attack		Renal Failure
	Alzheimer's Disease		High blood pressure		Seizure
	Arthritis		High cholesterol		Sleep Apnea
	Asthma		Hypertension		Stroke
	Cancer-type _____		Leukemia		Sudden Death
	Congestive heart failure		Loss of vision		Suicide
	Coronary artery disease		Lymphoma		Thyroid disorder
	COPD		Malignant melanoma		Ulcerative colitis
	Depression		Obesity		Varicose veins
	Diabetes		Osteoporosis		Vision problems
	Hearing loss		Pancreatitis		Other:

SURGERIES: (Check and write year)

	Abortion		Gall Bladder		Shoulder
	Adenoids		Gastric Bypass		Sinus
	Appendix		Heart Bypass		Tonsils
	Ankle		Heart Stent		Tubal Ligation
	Breast		Hernia		Vasectomy
	C-Section		Hysterectomy		Other:
	Ear tubes		Joints		Other:

HOSPITALIZATIONS/INJURIES: (Not including above surgeries)

_____

_____

MEDICATIONS: (List all medicines/doses you take regularly)

_____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICAL ALLERGIES: (Include reaction)

_____

_____

PREVENTATIVE EXAMS AND HEALTH:

When was your last colonoscopy? _____ When was your last EKG? _____

When was your last DEXA Scan? _____ When was your last cholesterol blood test? _____

Men only:

When was your last PSA blood test? _____ When was your last complete physical? _____

Women only:

When was your last pap smear? _____ When was your last mammogram? _____

Current method of birth control? _____ Number of pregnancies ___ Number of births ___

Number of miscarriages _____ Number of abortions _____

SOCIAL HISTORY:

_____ Married _____ Single _____ Divorced _____ Widowed

What is your occupation? _____ Employer: _____

Do you exercise regularly? Y N Type/Frequency: _____

Do you currently smoke tobacco? Y N If yes, how much per day? _____

How long have you smoked? _____ If no, have you ever smoked tobacco? Y N

How much per day? _____ How long did you smoke? _____

Do you drink alcohol? Y N If yes, how often do you drink _____

If no, are you a recovering alcoholic? Y N How long ago did you quit? _____