

Adult Health History

Name _____ Date _____ Birthdate _____

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

Genito-urinary

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

Gastrointestinal

- Appetitive poor
- Bowel changes
- Constipation

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

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding disorders
- Breast lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Colitis
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes
- High Cholesterol

- 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? _____

- HIV Positive
- Irritable Bowel Disease
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio
- Prostate problem
- Psychiatric care
- Rheumatic fever
- Scarlet fever
- Stroke
- Suicide attempt
- Thyroid problems
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Sexually Transmitted Illness
- Whooping cough

| | |
|--|---|
| 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 blood relatives had any of the following and describe their relationship to you | |
| Father | | | | | <input type="checkbox"/> Aneurysms _____ <input type="checkbox"/> Anxiety _____ <input type="checkbox"/> Arthritis, gout _____ <input type="checkbox"/> Asthma _____ <input type="checkbox"/> Autism _____ <input type="checkbox"/> Bipolar Disorder _____ <input type="checkbox"/> Brain Tumors _____ <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Cerebral Palsy _____ <input type="checkbox"/> Chemical Dependency _____ <input type="checkbox"/> Depression _____ <input type="checkbox"/> Epilepsy/Seizures _____ <input type="checkbox"/> Gonorrhea _____ <input type="checkbox"/> Headaches/Migraines _____ <input type="checkbox"/> Heart Disease _____ <input type="checkbox"/> High Blood Pressure _____ <input type="checkbox"/> Kidney Disease _____ <input type="checkbox"/> Learning Disabilities _____ <input type="checkbox"/> Mental Retardation _____ <input type="checkbox"/> Muscular Disease _____ <input type="checkbox"/> Obsessive Compulsive DO _____ <input type="checkbox"/> Schizophrenia _____ <input type="checkbox"/> Syphilis _____ <input type="checkbox"/> Tics _____ <input type="checkbox"/> Tuberculosis _____ | |
| Mother | | | | | | |
| Brothers | | | | | | |
| | | | | | | |
| | | | | | | |
| Sisters | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Health Habits check (✓) which substances you use and describe how much you use. | | | | Occupational Concerns check (✓) if your work expose you to the following: | | |
| | Caffeine | | | | | Stress |
| | Tobacco | | | | | Hazardous substances |
| | Alcohol | | | | | Heavy lifting |
| | Drugs | | | | Other | |
| | Other | | | | | |
| Exercise. How often and what kind of exercise do you do? _____ | | | | | | |
| Serious Illness/Injuries and Hospitalizations | | Date | Outcome | Pregnancy History | Complications if any. | |
| | | | | Year/Date of birth | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Preferences, habits, and particulars

Food

Which foods do you crave?
 Sweet Sour Salty Fats Breads
Appetite? Good Fair Poor
Thirst? Very thirsty Medium Not at all

Sleep Habits

Bed time? _____
Wake time? _____
Time to fall asleep? _____
Sleep position? _____

During sleep do you:
 Grind teeth Snore
 Perspire Walk
 Talk Have nightmares?
 Wake at night? Time _____

Fears

Claustrophobia Dark
 Heights Flying
 Thunder/Lightning Water
 Animals. Which ones? _____ Other _____

Temperature

Sense of body temperature? Chilly Warm
Hands? Chilly Warm
Feet? Chilly Warm

Other

Do you bite your nails? Yes No
Favorite book or movie? _____
Best time of day? _____ Worst time of day? _____
Do you recall your dreams? Yes No
Preferred Climate temperate desert mountain seashore
Most significant person in your life and why _____
