

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? _____

- 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? _____ During sleep do you:
Wake time? _____ Grind teeth Snore
Time to fall asleep? _____ Perspire Walk
Sleep position? _____ 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 _____
