Adult Health History

Name: _____ Date: _____ DOB: _____ Age: _____ Sex: _____

Primary Language: _____ Need for translator: Yes _____ No _____

Purpose of Initial Visit: _____

ALLERGIES

Drug: _____

Food: _____

Other: _____

CURRENT MEDS

Prescriptions:

Over the Counter:

FAMILY HISTORY

Use check (✓) mark for *Yes* answers	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Cancer						
Diabetes						
Epilepsy/Convulsions						
Glaucoma						
Heart Disease						
High blood pressure						
Kidney disease						
Mental illness						
Stroke						
Thyroid disease						
Drug or Alcohol Addiction						
Other:						

Past Medical History and Review of Systems

Please circle if you have had problems with or are presently complaining of any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/chest tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. Tuberculosis
17. Abdominal discomfort
18. Hay fever
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Ulcers
26. Gout
27. Hemorrhoids
28. Gall bladder disease
29. Unexplained weight gain/loss
30. Colitis
31. Hepatitis or jaundice
32. Thyroid disease
33. Head or neck radiation
34. Headache
35. Kidney diseases
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin diseases
41. Blood disorders
42. Venereal diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Change in bowel habits
49. _____
50. _____

Please list and supply the dates of:

Operations: _____

Hospitalizations other than for surgery: _____

Transfusions: _____

Immunization history -- have you had:

Hepatitis B? ☐ No ☐ Yes When? _____

Tetanus? ☐ No ☐ Yes When? _____

Pneumovax immunization? ☐ No ☐ Yes When? _____

Flu immunization? ☐ No ☐ Yes When? _____

Other? _____ ☐ No ☐ Yes When? _____

Adult Health History

Name: _____ Date: _____

When was your last:

Complete physical	Date: _____ Results: _____	TB test:	Date: _____ Results: _____
Cholesterol check	Date: _____ Results: _____	Pap smear	Date: _____ Results: _____
Eye exam	Date: _____ Results: _____	Mammogram	Date: _____ Results: _____
Hearing test	Date: _____ Results: _____	Breast exam	Date: _____ Results: _____
Stool check for blood	Date: _____ Results: _____	Prostate exam	Date: _____ Results: _____

FOR WOMEN ONLY: Gynecological and Obstetric History

Age at onset of periods: _____ Frequency: _____ Length of period: _____

Pregnancies: _____ Births: Miscarriages:

Abortions: _____

Prolonged or abnormal bleeding:	☐ No ☐ Yes	Please describe:	_____
Leakage of urine:	☐ No ☐ Yes	Please describe:	_____
Pelvic pain:	☐ No ☐ Yes	Please describe:	_____
Abnormal discharge:	☐ No ☐ Yes	Please describe:	_____
History of abnormal Pap smear:	☐ No ☐ Yes	Type of treatment:	_____

Prevention

Do you wear seat belts? ☐ No ☐ Yes If no, why not? _____

Do you wear a bike helmet? ☐ No ☐ Yes ☐ N/A _____

Do you drink beverages with caffeine? ☐ No ☐ Yes If yes, how many per day? _____

Do you smoke? ☐ No ☐ Yes If yes, how many packs per day? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, how much per week? _____

Do you use drugs (marijuana, cocaine, crack, etc.). ☐ No ☐ Yes If yes, explain: _____

Is there a gun in your home? ☐ No ☐ Yes

Is it unloaded & out of children's reach? ☐ No ☐ Yes ☐ N/A

Comments: _____

_____

Risk History

Currently sexually active? ☐ Yes ☐ No How many partners in the past 5 years? _____

Have you ever experienced:

Sex with same sex partner(s)?	☐ Yes ☐ No	Sex with injecting drug user?	☐ Yes ☐ No
Sex with female?	☐ Yes ☐ No	Sex with person with HIV/AIDS?	☐ Yes ☐ No
Sex while using drugs?	☐ Yes ☐ No	Sex with person with other HIV/AIDS risk?	☐ Yes ☐ No
Sex for drugs/money?	☐ Yes ☐ No	Ever been a victim of sexual assault?	☐ Yes ☐ No

Contraceptive: Method last used/now using: _____

History: Other methods used: _____

Problem(s) with methods: _____

Have you been in contact with persons with confirmed TB?	☐ No	☐ Yes If yes, explain:	
Are you from or have you recently traveled to regions of the world with high TB prevalence?	☐ No	☐ Yes If yes, explain:	
Are you exposed to the following: • HIV+ persons • Homeless persons • Migrant farm workers • IV/street drug users • Residents of nursing homes • Institutionalized/incarcerated persons	☐ No	☐ Yes If yes, explain:	
Have you ever worked with chemicals, paints, asbestos, or other hazardous material?	☐ No	☐ Yes If yes, explain:	

Are you in a relationship in which you have been physically hurt (e.g. slapped, kicked, punched, bruised) by your partner?	☐ No	☐ Yes	☐ N/A
Do you ever feel afraid of your partner?	☐ No	☐ Yes	☐ N/A

Do you have a "living will"? ☐ No ☐ Yes (If yes, please provide a copy)

Do you have a donor card? ☐ No ☐ Yes

Signature: _____

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