Patient Name_____

Date of Birth_____

Adult Health History

This form will assist us in obtaining a complete medical history and health record on you. By completing this ahead of time it will also simply your visit and intake process with our office. If you are uncertain or uncomfortable with a question it can be left blank.

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 (shingles) _____ HPV _____

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 or intolerance to medications (include type of reaction): **NONE** □

_____

_____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) Date _____ Abnormal? □ No □ Yes
Fasting Blood sugar Date_____ Abnormal? No Yes
Sigmoidoscopy or Colonoscopy (circle one) Date _____ Polyp? □ No □ Yes
Women only: Mammogram Date _____ Abnormal? □ No □ Yes
Pap Smear Date _____ Abnormal? □ No □ Yes
Bone Density Test Date _____Abnormal? □ No □ Yes

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you had (past) any of the following conditions? □ **NONE**

Condition	***Code***	***Current***	***Past***	***Comments***
Alcohol / Drug abuse	305.00/305.90			
Allergy (Hay Fever)	477.9			
Anemia	285.9			
Anxiety	300			
Arthritis (Rheumatoid)	714			
Arthritis (Osteoarthritis)	715.9			
Asthma	493.9			
Bladder / Kidney Problems				
Blood Clot (leg)	453.4			
Blood Clot (lung)	415.11			
Blood Transfusion	V58.2			
Breast Lump (benign)	611.72			
Cancer Breast	174.9			
Cancer Colon	153.9			
Cancer Other Type				
Cancer Ovarian	183			
Cancer Prostate	185			
Cataracts	366.9			
Chicken Pox	52.9			
Colon Polyp	211.3			
Coronary Artery Disease	414			
Depression	311			
Diabetes (adult onset)	250			
Diabetes (childhood onset)	250.01			
Diverticulosis	562.1			
Emphysema	492.8			
Fractures (broken bones)				Where?
Gallbladder Disease	574.2			
Gastroesophageal Reflux (Heartburn/GERD)	530.81			
Glaucoma	365.9			
Gout	274.9			
Gynecological Conditions (Endometriosis)	617.9			
Gynecological Conditions (Fibroids)	218.9			
Gynecological Conditions (Other)				
Heart Attack	410.9			
Hepatitis – Type A	70.1			
Hepatitis – Type B	70.3			
Hepatitis – Type C	70.51			

Personal Medical History Continued:

Condition	*Code*	*Current*	*Past*	*Comments*
Hepatitis – Other	70.59			
High Blood Pressure	401.9			
High Cholesterol	272			
Hip Fracture	820.8			
Irritable Bowel Syndrome	564.1			
Kidney Disease / Failure	586			
Kidney Stones	592			
Liver Disease	573.9			
Migraine Headaches	346.9			
Osteoporosis	733			
Pneumonia	486			
Prostate (enlargement)	600			
Prostate (nodules)	600.1			
Seizure / Epilepsy	780.39			
Skin Condition (Eczema)	692.9			
Skin Condition (Psoriasis)	696.1			
Skin Condition (Abnormal Moles)	238.2			
Sleep Apnea	780.57			
Stomach Ulcer	531.9			
Stroke	434.91			
Thyroid (Nodule)	241			
Thyroid High (Overactive) / Hyperthyroidism	242.9			
Thyroid Low (Underactive) / Hypothyroidism	244.9			
Other (list)				
Other (list)				

Surgical Procedure	*Code*	*Yes*	*Year*	*Comments*
Abdominal Surgery				
Appendectomy (appendix removal)				
Back Surgery (lumbar)				
Biopsy (location)				
Breast Biopsy				Circle: Right Left Both
Breast Surgery				Circle: Right Left Both
Colonoscopy				
Coronary Bypass				
Coronary Stent				
EGD (Stomach Endoscopy)				
Cataract				
Gallbladder Removal				Circle: Laparoscopic
Heart Surgery (other than coronary bypass)				
Surgical Procedures	*Code*	*Yes*	*Year*	*Comments*

Continued				
Hip Surgery				Circle: Right Left Both
Hysterectomy (total, including ovaries)				Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (partial, ovaries left)				Circle: Laparoscopic Vaginal Abdominal
Knee Surgery				Circle: Right Left Both
LEEP (Cervix Surgery)				
Neck Surgery				
Ovary Ligation ("Tubal")				
Ovary Removal				Circle: Right Left Both
Vasectomy				
Sigmoidscopy				
Sinus Surgery				
Other (list)				

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 Breast										
Cancer Colon										
Cancer Other Type										
Cancer Ovarian										
Cancer Prostate										
Colon Polyp										
Coronary Artery Disease (e.g. heart attack, angina) Depression / Suicide / Anxiety										
Diabetes (childhood onset)										
Diabetes (adult onset)										

Disease Continued :	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
High Blood Pressure - Hypertension										
High Cholesterol										
Hip Fracture										
Hypothyroidism / Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Other (list)										

OTHER HEALTH ISSUES:

Tobacco Use
Smoke cigarettes: □ Never □ No □ Yes

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: _____

Drug Use
Do you use marijuana or recreational drugs? □ No □ Yes
Have you ever used needles to inject drugs? □ No □ Yes

Exercise: Do you exercise regularly? □ Yes □ No
What form 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

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, IUD, vasectomy, other

Have you completed an Advance Directive or living will?
□ No □ Yes

Is violence at home a concern for you?
□ No □ Yes

Have you completed an Advance Directive ?

SOCIAL HISTORY:
Occupation (or prior occupation): _____
retired/unemployed/leave of absence/disabled (circle one if applicable)

Employer: _____ Years of education or highest degree: _____

Marital status (circle one): single, partner, married, divorced, widowed, other: _____
Spouse/partner's name: _____ Number of children: _____

Sports, hobbies: _____
_____
_____

WOMEN'S HEALTH HISTORY:
Total number of pregnancies: _____ Number of births: _____
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): _____

Thank you for taking the time to fill this out.