Adult History Form Patient Name:

Date of Birth:	Home Phone:	Work Phone:

Please list **SPECIAL PROBLEMS** you would like evaluated today in order of significance:

1.

2.

3.

4 .

MEDICATION ALLERGIES: (such as penicillin) What happens when you take that medicine:	**OTHER ALLERGIES**: (such as bees/wasps, foods, latex, etc) What happens when you are exposed:

MEDICATIONS: Prescription and Non-Prescription
(including aspirin, vitamins, birth control, herbs, supplements, etc.)

PAST MEDICAL HISTORY

Please describe and give dates of any illnesses, injuries, hospitalizations, and surgeries:

IMMUNIZATIONS

Hepatitis B Yes No Date:	Hepatitis A Yes No Date:	Shingles vaccine? Yes No Date:
Tetanus Yes No Date:	Influenza (flu) Yes No Date:	"Pneumonia Shot" Yes No Date:

Have you had Chickenpox? Yes No Date:	MMR (Measles, Mumps, Rubella) Yes No Date:

Have you ever had a test for Tuberculosis? if yes (circle one) : Positive / Negative
Date:

Have you ever had a blood transfusion? if yes: Dates:

Comments/Changes

Initials: Date:

Adult History Form

Comments/Changes

FAMILY HISTORY

Please check any family members who have the following health problems.

	Father	Mother	Brother	Sister	Grandparent	Other
Diabetes						
Glaucoma						
Cancer (List type)						
Heart attack						
Angina						
Stroke						
High blood pressure						
High cholesterol						
Alcoholism						
Drug Abuse						
Depression						
Mental Illness						
Suicide						
Other health problems						

SOCIAL HISTORY

Please Circle: Married Single Divorced Widowed Other	Children: Yes No How many? ____
Your Occupation:	Place Employed:
Level of Education: High-School College Graduate Doctorate Other	Hobbies:

Recent Significant Changes in Your Life? Yes No

Financial Hardships? Yes No

Have Special Stresses in Your Life? Yes No

I am **NOT** happy with (circle those that apply) → Myself My Health My Work My Partner My Life

Have you ever used **tobacco products** regularly? Yes__ No__ if yes, please continue below:

Tobacco Product	Age Started Using	# of years used?	Amount each day	Still Use?

Circle the **beverages** you regularly consume and list the amount per WEEK:

Coffee/Tea: Beer: Wine: Hard liquor: Soda:

Initials: Date:

Drugs and Alcohol can sometimes effect your health and the medications you take.
Please answer the following:

1. In the last year, how many times have you not remembered things that happened while you were drinking or using drugs?	5 or more 3-4 1-2 0
2. In the last year, have you drunk or used drugs more than you meant to?	Yes No
3. Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Yes No
4. In the last year, have you drunk or used non-prescription drugs to deal with your feelings, stress, or frustration?	Yes No

CURRENT HEALTH PRACTICES

Food, exercise, and safety can all play a role in your health.
Please answer the following questions to see what areas might put you at risk.

Do you exercise regularly? yes / no Type of exercise and frequency:

How many meals do you eat per day? Snacks per day?

Adult History Form

Adult History Form	Comments/Changes
How many meals do you eat out per week?	
Amount and type of **dairy products** you consume per day:	
List any nutrition or diet concerns you would like help with:	
If you are on a **special diet**, please explain:	
Are you happy with your weight? Yes __ No __	
Do you have regular **Eye** exams? Y__ N__	
Do you have regular **Dental** check-ups? Y__ N__	
Have you been exposed to any **Toxic Substances**, such as asbestos, DES, radiation, chemicals? yes___ no___ if yes, please explain:	
	Initials: Date:
REVIEW OF SYSTEMS: Circle those items you currently have significant problems with, and describe:	
GENERAL	

Recent Weight Change	Increased Thirst or Urination	Night Sweats/Hot Flashes
Always Hot/Always Cold	Rashes or Skin Problems	Significant Fatigue

Do you have chronic pain problems? Yes No

BREASTS: Men & Women

Lumps/Tenderness	Do You Do Monthly Self Breast Exams? Y__N__
Drainage from Nipple	Month and Year of Last Mammogram:__________

EYE, EAR, NOSE, AND THROAT

Glaucoma	Blurred or Double Vision- Ever	Use Glasses or Contact Lenses
Hearing Loss	Brief Loss of Vision- Ever	Use Dentures (Partial or Total)
History of Radiation Therapy to Head or Neck		Teeth or Gum Problems

CARDIOPULMONARY

Shortness Of Breath With Activity	Dizziness	Chest Pain
Daily Sputum (Phlegm) Production	Coughing Up Blood	Heart Palpitations
Difficulty Breathing While Lying Flat	Leg Cramps While Walking	Wheezing
Waking Up Short of Breath	Daily Cough	Ankle Swelling

GASTROINTESTINAL

Change of Appetite	Abdominal Pain	Blood in Stool/Black Stool
Difficulty Swallowing	Diarrhea/Constipation	Frequent Nausea/Vomiting
Heartburn	Indigestion From Fatty Foods	

NEUROPSYCHIATRIC

Frequent Disabling Headaches	Difficulty Sleeping	Tremors
Frequent Anxiety or Anxiety Attacks	Memory Loss	Passing Out/Fainting
Treated in Past for Emotional or Psychological Problems: please describe ______________		Often Feel Sad or Depressed

MUSCULOSKELETAL & SKIN

Frequent Neck or Back Pain	Muscle Pain	Disabling Night Leg Cramps
Joint Problems	Use a Brace or a Splint	

Mole that has changed color, size, shape, or won't heal? Yes No

GENITOURINARY: MEN & WOMEN

Urinary Tract Infections	Sores in the Genital Area
Difficult or Painful Urination	Blood in Urine
History of Kidney or Bladder Stones	Urination More Than Once a Night
History of Four or More Sex Partners	Sexual Intercourse Before 18 years old
Method of Birth Control:	

Have you ever had any Sexually Transmitted Disease: Yes___ No___
if yes, please describe:

GENITOURINARY: MEN ONLY

Pain or Lump in Testicles/Scrotum	Do you do Self Testicular Exam: Yes___ No ___

Adult History Form

Comments/Changes

GENITOURINARY: WOMEN ONLY		Comments/Changes
Age of first Period	Frequency/Length of Menstrual Periods: _______	
Date of Last Menstrual Period: ________	Change in Menstrual Pattern	
Number of Pregnancies: _____________	Number of Children: ________	
Disabling Menstrual Cramps	Unusual Vaginal Discharge/Itching	
Date of Last Pap Smear: __________		
History of Abnormal Pap Smear: Y N	Any Treatments for Abnormal Pap:	Initials: Date:

Sexual Health is an important part of an individual's overall physical and emotional well-being.
If I don't ask about Sexual Health, patients will not always bring the issue up during the interview.
Therefore, I've begun asking all patients about their Sexual Health.

Male Sexual Health

Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health.
Following are several questions regarding sexual function.
Place an "X" on the line where your answer to the question would be.

1. How do you rate your confidence that you could get and keep an erection?

Very low -- Very high

2. How often were you able to maintain an erection?

Rarely -- Almost always or always

3. How difficult was it to maintain your erection to completion of intercourse?

Very difficult --- Not difficult

4. When you attempted sexual intercourse, how often was is satisfactory for you?

Never satisfactory -- Almost always or always

5. Is sexual intercourse usually painful?	Yes	No	Initials: Date:

To the best of my knowledge, this is an accurate statement of my health:

Signature:_________________________ Date: ________

Female Sexual Health

Please answer the following questions as truthfully as possible.

1. In the past month, did you **usually** feel sexually aroused ("turned on") during sexual activity or intercourse?	Yes	No
2. In the past month, have you been **satisfied** with the amount of vaginal lubrication ("wetness") during sexual intercourse?	Yes	No
3. In the past month, when you had sexual stimulation or intercourse, did you **usually** reach orgasm (climax)?	Yes	No
4. In the past month, have you been **satisfied** with your sexual relationship with your partner?	Yes	No
5. In the past month, did you experience discomfort or pain during vaginal penetration?	Yes	No
6. Is your partner having sexual health issues that you would like to discuss?	Yes	No

To the best of my knowledge, this is an accurate statement of my health:

Signature:_________________________ Date: ________

Initials: Date: