ADULT HEALTH HISTORY

Name: ____________________ **Age:** ________
Date: ____________________
Previous Doctor: ____________________________________

Please take a few minutes to fill out both sides of this questionnaire. It will become part of the permanent medical record. All answers are confidential.

Main problem that you are here for: ____

LIST ALL SURGERIES

Year	Surgery

LIST ALL HOSPITALIZATIONS

Year	Illness

MEDICATIONS DOSE FREQUENCY

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

ALLERGIES

Medication Reaction Year

1. ______________________________
2. ______________________________
3. ______________________________

LAST IMMUNIZATION	**YEAR**
Pneumovax	______
Flu	______
Tetnaus	______
Chicken Pox	______
Hepatitis B	______

FAMILY HISTORY

	Living	Dead	Age	Medical Conditions
Father				
Mother				
Brothers				
Sisters				
Children				

Any other family members with serious conditions. Give relationships and disease.

SOCIAL HISTORY

Occupation: ______________________________

Retired (year) _______ **Yes** **No**

Marital Status ______________________

With whom do you live? ____________________

Residence location: ______________________

Hobbies: __________________________________

Smoking ______________ **packs per day**

Alcohol ________________ **per week**

Coffee ________________ **cups per day**

REVIEW OF SYSTEMS (Check all that apply)

NEUROLOGIC
______ Stroke
______ Seizures
______ Fainting
______ Light Headedness
______ Spinning Dizziness
______ Significant Headaches
______ Numbness or Tingling
______ Weakness of a Body Part
______ Alzheimer's
______ Parkinsonism

EYES
______ Loss of Vision
______ Cataracts
______ Glaucoma
______ Eye Pain
______ Double Vision

EARS
______ Deafness
______ Ringing
______ Frequent Infection
______ Significant Wax

NOSE & THROAT
______ Sinus Infection
______ Nasal Stuffiness
______ Runny Nose
______ Nosebleeds
______ Bleeding Gums
______ Abnormal Swallowing
______ Hoarseness
______ Allergies or Hay Fever

RESPIRATORY
______ Emphysema/COPD
______ Asthma
______ Frequent Cough
______ Sputum Production
______ Coughing Up Blood
______ Pain with Breathing
______ Shortness of Breathing (SOB)
______ SOB if you Sleep on 1 Pillow
______ Awaken with SOB

HEART
______ High Blood Pressure
______ High Cholesterol
______ Heart Attack
______ Angina
______ Chest Pain or Pressure
______ Fast Heartbeat
______ Slow Heartbeat
______ Irregular Heartbeat
______ Poor Circulation
______ Swelling of Feet
______ Heart Murmur

LIVER
______ Gallstone History
______ Jaundice History
______ Hepatitis History

GASTROINTESTINAL
______ Ulcer History
______ Heartburn
______ Nausea or Vomiting
______ Belly Pain
______ Black or Bloody Stools
______ Diarrhea
______ Constipation
______ Weight Loss

KIDNEY
______ Stones
______ Infection

URINARY
______ Burning
______ Bloody
______ Dribbling
______ Frequent
______ More Than Once Nightly
______ Weak Stream

BLOOD
______ Transfusion History
______ Blood Clot
______ Anemia (Low Blood Count)

INFECTION HISTORY
______ Exposure to TB
______ Positive TB Test
______ Rheumatic or Scarlet Fever
______ Salmonella or Shigella
______ Gonorrhea or Syphilis
______ Chlamydia or PID
______ AIDS or HIV

MUSCULOSKELETAL
______ Arthritis
______ Gout
______ Joint Pain
______ Joint Swelling
______ Neck Pain
______ Back Pain
______ Hernia

ENDOCRINE
______ Diabetes
______ Thyroid Problem

PSYCHOLOGICAL
______ Depression
______ Anxiety Disorder
______ Nervous Breakdown
______ Excessive Worry
______ Crying Spells
______ Sleeping Difficulty
______ Thoughts of Suicide

SKIN/MUCOSA
______ Psoriasis
______ Cancer
______ Gingivitis or Bleeding Gums
______ Dentures

MEN
______ Prostate Enlargement
______ Other Prostate Problems
______ Sexual Difficulty

WOMEN
______ Last Menstrual Period (When ____________________)
______ Painful Menstrual Periods
______ Other Menstrual Problems
______ Menopause (When ______________________________)
______ Bleeding after Menopause
______ Number of Pregnancies
______ Number of Miscarriage
______ Sexual Difficulty

OTHER CONCERNS: ____

____

Are you concerned that you may have a special disease?

____