Adult Health History

Legal Name: _____
First Last

Name you like to be called:_____ **Date of Birth**:_____

Legal sex: ☐ Male ☐ Female ☐ X

Gender: ☐ Woman ☐ Man ☐ Trans Woman ☐ Trans Man ☐ Non-binary ☐ Genderqueer ☐ Agender ☐ Not Listed:_____

Filling out this form

Answering these questions will help your doctor understand your health and how to best treat you. If you need help filling out this form, the clinic staff will help you.

GENERAL

1. Are you ☐ Single ☐ Married ☐ Partnered ☐ Divorced or Separated ☐ Widowed ☐ Other:_____
2. Where did you grow up?_____
3. What kind of **work** do you do or, if retired, what did you do?_____
4. What level of education did you complete?_____
5. When was the last time you were **seen by a primary care doctor**?_____
   Who did you see? _____
6. Do you have an Advance Directive or Living Will? ☐ Yes ☐ No
7. Do you have a POLST (Physician Order for Life Sustaining Treatment)? ☐ Yes ☐ No

Please bring Advance Directive, Living Will and/or POLST forms to your appointment.

ALLERGIES

8. Have you ever had any **allergic reaction (bad effect**) to a medicine or shot?

☐ No ☐ Yes Please write the name of the medicine or shot and the effect you had below.

Medicine I am allergic to	What happens when I take that medicine
EXAMPLE: Atenolol	I get a rash

9. Do you get an **allergic reaction (bad effect)** from any of the following?

☐ No, I have no allergies. ☐ Yes. *Check all that apply*

Allergic to	**What happens**
☐ Latex (rubber gloves)	
☐ Grass or Pollen	
☐ Eggs	
☐ Shellfish	
☐ Other:	
☐ Other:	

MEDICINES

10. Are you taking any **prescription medicines?**

☐ No, I do not take any prescription medicines.

☐ Yes. List your medicines below **OR** ☐ I brought my pill bottles or a list

Pharmacy:_____ Phone Number:_____

Medicine name	**Strength or Amount**	**How many pills or doses do you take at a time?**			
EXAMPLE: Furosemide	20mg	2 morning	1 noon	dinner	bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed

11. Do you regularly take any **over-the-counter, vitamins and nutritional supplements**?

☐ No ☐ Yes Check all that apply and enter "Strength or Amount" for those you are taking.

Name of medicine	Strength or Amount
☐ Pain Reliever (examples: Tylenol, Advil, Motrin, Aleve, Aspirin)	
☐ Vitamins	
☐ Antacid (examples: Tums, Prilosec)	
☐ Herbal medicine, please list:	
☐ Nutritional supplements, please list:	
☐ Other, please list:	

MEDICAL HISTORY

12. Have you **ever** had any of the following **health problems**? *Check all that apply.*

☐ Abnormal pap (not normal pap test)	☐ Hepatitis (disease that affects the liver)
☐ Allergies	☐ High blood pressure
☐ Anemia (low iron, low blood count)	☐ High cholesterol
☐ Anxiety	☐ HIV/AIDS
☐ Arthritis	☐ Jaundice (skin and eyes turn yellow)
☐ Asthma (breathing disease)	☐ Kidney disease
☐ Blood transfusion	☐ Kidney stones
☐ Bowel disorder	☐ Liver disease
☐ Cancer (type: _____)	☐ Meningitis
☐ Cataracts	☐ Osteoporosis (weak bones)
☐ Chronic obstructive pulmonary disease	☐ Prostate problems
☐ Clotting disorder	☐ Seizures
☐ Congestive heart failure (CHF)	☐ Sexually transmitted disease
☐ Depression (feeling low or blue)	☐ Shingles (painful skin rash)
☐ Diabetes (high blood sugar)	☐ Sickle cell (disorder affecting red blood cells)
☐ Emphysema (lung disease)	☐ Skin problems
☐ GERD (heartburn, acid reflux)	☐ Stroke
☐ Glaucoma	☐ Substance abuse (illegal drugs, drug problem)
☐ Gout (joint pain in toes)	☐ Thyroid disease
☐ Hearing loss	☐ Tuberculosis (TB, lung disease)
☐ Heart attack	☐ Urinary problems (problem peeing)
☐ Heart murmur (extra noise heart makes)	☐ OTHER:

SURGICAL HISTORY

13. Have you **ever** had **surgery?**

☐ No, I have never had surgery ☐ Yes. *Please list each surgery below.*

Surgery	Date

FAMILY HISTORY

14. Have any of your **family members** ever had any of the following health problems?
Check all that apply

	Name	Alive?	No known history	Cancer	Diabetes	Heart problems	High Blood Pressure	Stroke	Thyroid disease	Other
Mother		☐Yes ☐No								
Father		☐Yes ☐No								
Sister		☐Yes ☐No								
Sister		☐Yes ☐No								
Brother		☐Yes ☐No								
Brother		☐Yes ☐No								
		☐Yes ☐No								
		☐Yes ☐No								

SOCIAL HISTORY

15. Do you drink **alcohol**?
    - ☐ No
    - ☐ Yes, please answer the questions below:

        ☐ Wine (glasses a week)_____How many years?_____Date quit?_____
        ☐ Beer (cans a week) _____How many years?_____Date quit?_____
        ☐ Liquor (shots a week)_____How many years?_____Date quit?_____

16. Do you use **drugs**? (this information is not reported)
    - ☐ No
    - ☐ Yes, please answer the questions below:

    Used within the last week? ☐ No ☐ Yes, how many times?_____

    Types of drugs used: *check all that apply*

    ☐ Marijuana ☐ Methamphetamines ☐ Cocaine ☐ Heroin
    ☐ Other:_____

17. Have you ever **smoked cigarettes, cigars, smoked a pipe, used snuff or chewed tobacco**?
    - ☐ No
    - ☐ Yes, please answer the questions below:

        ☐ Cigarette (packs a day):_____How many years?_____Date quit?_____
        ☐ Cigar (number a day):_____How many years?_____Date quit?_____
        ☐ Pipe (number a day):_____How many years?_____Date quit?_____
        ☐ Snuff (number a day):_____How many years?_____Date quit?_____
        ☐ Chew (number a day):_____How many years?_____Date quit?_____

    Do you want to quit? ☐ Yes ☐ No ☐ I already have quit

18. Do you have sex with ☐ Men ☐ Women ☐ Both ☐ I don't have sex

    If you use birth control, what type do you use? *Check all that apply*

☐ Abstinence ☐ Rhythm (calendar tracking) ☐ Inserts ☐ Implant
☐ Condom ☐ Tubal Ligation (tubes tied) ☐ IUD ☐ Vasectomy
☐ Injection ☐ Withdrawal or pullout method ☐ Birth Control Pills ☐ Diaphragm
☐ Post-menopausal ☐ Other:_____

EXERCISE

19. Do you exercise 2 or more days a week? ☐ Yes ☐ No

20. What do you do for exercise?_____

IMMUNIZATIONS (Shots)

21. Have you had the following shots?

☐ Flu	Date _____	Where given _____
☐ Tetanus –Diphtheria (Td)	Date _____	Where given _____
☐ Tetanus-Diphtheria-Pertussis (Tdap)	Date _____	Where given _____
☐ HPV (Gardasil)	Date _____	Where given _____
☐ Pneumovax/Prevnar	Date _____	Where given _____
☐ Shingrix (shingles)	Date _____	Where given _____
☐ Hepatitis A	Date _____	Where given _____
☐ Hepatitis B	Date _____	Where given _____
☐ MMR	Date _____	Where given _____

SPECIALTY SERVICES

22. Are you **currently** seeing any other doctors?

Doctor's Name: _____ Type of Doctor: _____

When Last Seen: _____ Phone Number: _____

Doctor's Name: _____ Type of Doctor: _____

When Last Seen: _____ Phone Number: _____

Doctor's Name: _____ Type of Doctor: _____

When Last Seen: _____ Phone Number: _____

Dentist's Name: _____ Type of Doctor: _____

When Last Seen: _____ Phone Number: _____

Anything else we should know?