Adult Health History

Name: ________________________________ Name you like to be called:______________
First Last

Today's Date: ______________ Date of Birth: _____________

☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male

Filling out this form

Answering these questions will help your doctor understand your health and how best to 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
2. What kind of **work** do you do or, if retired, did you do? ____________________________
3. When was the last time you were **seen by a primary care doctor**? __________________

   Who did you see? ____
4. Do you have an **Advance Directive** or **Living Will**? ☐ Yes ☐ No
   These are written statements about how you want to be treated if you get very sick.
5. Do you have a **POLST** (Physician Order for Life Sustaining Treatment)? ☐ Yes ☐ No

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

ALLERGIES

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

   ☐ No, I am not allergic to any medicines or shots.

   ☐ 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

continued on next page

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

☐ No, I have no allergies that I know of.

☐ Yes. *Check all that apply*

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

MEDICINES --

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

I do not take any prescription medicines.

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

Pharmacy:_______________________________ Phone Number:___________________

Name of medicine	Strength or Amount	How many pills or doses do you take at a time?
Furosemide	20 mg	_2_morning _2_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
		____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

continued on next page

9. What **over-the-counter drugs, vitamins and nutritional supplements** do you take regularly?

☐ No, I do not take any over-the-counter drugs, vitamins or nutritional supplements.

☐ 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 --

10. Have you **ever** had any of the following **health problems**?

☒ *Check all that apply*

☐ Anemia (low iron, low blood count)
☐ Asthma (breathing disease)
☐ Depression (feeling down or blue)
☐ Emphysema (lung disease)
☐ Glaucoma (eye disease)
☐ Headaches
☐ Heart Attack
☐ Hepatitis (disease that affects the liver)
☐ High Cholesterol (fat found in the blood)
☐ Jaundice (skin and eyes turn yellow)
☐ Kidney Stones
☐ Meningitis
☐ Prostate Problems
☐ Sexually Transmitted Disease
☐ Sickle Cell (disorder affecting red blood cells)
☐ Stroke
☐ Thyroid Disease
☐ Ulcers (open sores)
☐ Anxiety
☐ Cancer
☐ Diabetes (high blood sugar)
☐ GERD (heartburn, acid reflux)
☐ Gout (joint pain in toes)
☐ Hearing Loss
☐ Heart Murmur (extra noise heart makes)
☐ High Blood Pressure
☐ HIV/AIDS
☐ Kidney Disease
☐ Liver Disease
☐ Osteoporosis (weak bones)
☐ Seizures
☐ Shingles (painful skin rash)
☐ Skin Problems
☐ Substance Abuse (illegal drugs, drug problem)
☐ Tuberculosis (TB, lung disease)
☐ Urinary Problems (problems peeing)
☐ Other problems: ______________________________

continued on next page

SURGICAL HISTORY --

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

☐ No, I have never had surgery

☐ Yes. Please list each surgery below.

Surgery	When

FAMILY HISTORY --

12. Have any of your **family members** ever had any of the following health problems?

☒ *Check all that apply*

Mother ☐ Alive ☐ Passed Away	☐ Diabetes ☐ Cancer, type: ____________________ ☐ Other: ____________________	☐ High Blood Pressure	☐ Heart Problems
Father ☐ Alive ☐ Passed Away	☐ Diabetes ☐ Cancer, type: ____________________ ☐ Other: ____________________	☐ High Blood Pressure	☐ Heart Problems
Sisters # sisters: _____	☐ Diabetes ☐ Cancer, type: ____________________ ☐ Other: ____________________	☐ High Blood Pressure	☐ Heart Problems
Brothers # brothers: _____	☐ Diabetes ☐ Cancer, type: ____________________ ☐ Other: ____________________	☐ High Blood Pressure	☐ Heart Problems

continued on next page

SOCIAL HISTORY ---

13. 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? ________

14. Do you use **drugs**?
    - ☐ 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: ____

15. 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? ☐ No ☐ Yes ☐ Already quit

16. 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 (no sex) ☐ Coitus Interruptus (withdrawal or pullout method)

    ☐ Condom ☐ Diaphragm ☐ Implant

    ☐ Injection ☐ Inserts ☐ IUD

    ☐ Birth Control Pills ☐ Patch ☐ Post-menopausal

    ☐ Rhythm (calendar tracking) ☐ Spermicide ☐ Sponge

    ☐ Tubal Ligation (tubes tied) ☐ Vasectomy (male surgery for birth control)

    ☐ Other ____

17. **Exercise.** Do you exercise 2 or more days a week? ☐ No ☐ Yes

continued on next page

IMMUNIZATIONS (Shots) --

18. Have you had any of the following shots?

☐ Flu Year ______ Where given _________________
☐ Tetanus –Diptheria (Td) Year ______ Where given _________________
☐ Tetanus-Diptheria-Pertusis (Tdap) Year ______ Where given _________________
☐ HPV (Gardasil) Year ______ Where given _________________
☐ Pneumovax (pneumonia) Year ______ Where given _________________
☐ Zostavax (shingles) Year ______ Where given _________________
☐ Hepatitis A Year ______ Where given _________________
☐ Hepatitis B Year ______ Where given _________________
☐ MMR Year ______ Where given _________________

SPECIALTY SERVICES --

19. 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:________________________

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:________________________

Doctor's Name:____________________ Type of Doctor:_________________________
When Last Seen:__________________ Phone Number:________________________