HEALTH HISTORY – Adult	Name: ☐ Female ☐ Male
	Date of Birth: ____/____/____

Please complete this form to help us give you the best possible care

Language spoken: ☐ English Other: ☐ Interpreter used – Name:

Check conditions below that YOU have now or have had in the past.

☐ Alcoholism/drug addiction
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeding disorder
☐ Blood clot in leg or lung
☐ Cancer _____
☐ Depression
☐ Diabetes – type: _____
☐ Epilepsy /Seizures
☐ Genital discharge / pain
☐ Heart Disease / Attack
☐ Hepatitis – type: _____
☐ High blood pressure
☐ Kidney disease
☐ Lung disease
☐ Mental health problems
☐ Migraines
☐ Rheumatic fever
☐ Sexually transmitted infection
☐ Stomach problems
☐ Stroke
☐ Tuberculosis
☐ Thyroid _____
☐ Ulcer
☐ Urinary problems / pain

Hospitalization, surgery, serious injuries	year

Allergies:

Current Medications: *Include prescription, vitamins and over the counter / herbal preparations.*

WOMEN's Health: First menstrual period – Age:_____
Last menstrual period – date: ____/____/____
☐ Menopause – year: _____
OB History: Pregnancies:_____ Living Children:_____
Miscarriages/ Abortions:_____
Birth control: ☐ none ☐ pills Other: _____
Last mammogram- year: _____ ☐ Normal ☐ Abnormal
Do you perform ***Breast Self Exam?*** ☐ Yes ☐ No
Last pap smear – year: _____ ☐ Normal ☐ Abnormal

MEN's Health: Last prostate exam - year: _____
Do you perform ***Testicular Self Exam?*** ☐ Yes ☐ No

FAMILY HISTORY

Check if any family members have had any of the following: *Write relationship to you in the space.*

☐ Alcoholism, drug addiction
☐ Cancer – type:
☐ Depression
☐ Heart disease
☐ High blood pressure
☐ Lung disease (emphysema/TB)
☐ Stroke

Relationship status: ☐ Single ☐ Spouse/partner ☐ Widowed
Education (last grade/degree completed): _____
Your occupation: _____
Do you feel physically and emotionally safe in your relationship and your home? ☐ Yes ☐ *No*
Do you have financial concerns? ☐ No ☐ *Yes*
Do you exercise? ☐ No ☐ Yes – activity: _____
How often? _____
Alcohol ☐ No ☐ Yes type: _____ frequency:_____
Drugs ☐ No ☐ Yes type: _____ frequency:_____
Tobacco ☐ No ☐ Yes # per day:_____ since:_____
If yes, *would you like help quitting?* ☐ *No* ☐ *Yes*

NUTRITION

Special diet: _____
Significant weight change in the past 6 months?
☐ No ☐ Yes - _____ lbs. ☐ gain ☐ loss
Do you get enough to eat? ☐ Yes ☐ *No*
Do you have problems with chewing or swallowing?
☐ No ☐ *Yes - describe:*_____

Last exam	Provider	month/year
Medical		
Dental		
Eye		
Hearing		
Colon Screening		

Completed by: _____ ☐ Patient Other: _____

Provider Review / Signature: _____

HEALTH HISTORY – ADULT	Date: ____/____/____