Adult Health History Form

Please fill out this form prior to your visit today.

Health concern today: _____

New health problems since last visit:_____

New medications or supplements since last visit: _____

How many times in the last year have you had 4 or more drinks in a day?_____ How many drinks per week? _____

Do you smoke tobacco? (Y / N) Did you smoke in the past? (Y / N) Years? _____ Packs/day? _____

Drug use: (Y / N) What type? _____

Exercise: Type? _____ Minutes per day?_____ Days per week? _____

Over the past 2 weeks, how often have you been bothered by the following symptoms or problems:

Little interest or pleasure in doing things:

Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day ☐

Feeling down, depressed or hopeless:

Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day ☐

How often does your partner hurt you, threaten to hurt you or insult or talk down to you?

Never ☐ Sometimes ☐ Frequently ☐

Social History

☐ No change from last visit

Occupation: _____

Relationship status: Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed ☐

Partner(s) is/are: Male ☐ Female ☐ Do you have children? (Y / N) How many? _____

Are you sexually active? (Y / N) Do you use contraception? (Y / N) If so, what form? _____

Family History

☐ No change from last visit

Do your parents, brothers, sisters or grandparents have any of the following health problems?

Cancer _____ What type?_____ At what age? _____

Diabetes _____ Heart disease _____ High blood pressure _____ Stroke _____

Other health problems?_____

Patient Name:

DOB:

MRN:

Clinic Location:

Health System Review

Check the box if you have any of the following symptoms or problems:

- ☐ Unexplained weight loss
- ☐ Joint/back pain
- ☐ Concerning skin change
- ☐ Change in vision
- ☐ Hearing loss
- ☐ Difficulty swallowing
- ☐ Anxiety
- ☐ Difficulty breathing
- ☐ Cough
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Abdominal pain
- ☐ Constipation or diarrhea
- ☐ Black or bloody stools
- ☐ Vaginal discharge, itching, odor or abnormal bleeding
- ☐ Blood in the urine
- ☐ Leaking urine
- ☐ Menstrual Concern
- ☐ Difficulty urinating
- ☐ Numbness or tingling
- ☐ New or concerning headache
- ☐ Excessive thirst or frequent urination

Please review attached medication list and cross out any medications you are not taking. Circle any medications you need refilled.

_____

_____

For new patients only:

Significant medical events and chronic health problems:

_____ _____

_____ _____

_____ _____

Previous surgeries:

_____

Current medications (including supplements):

_____ _____

_____ _____

_____ _____

Allergies or reactions to medications:

_____

Vaccinations:

Tetanus/Whooping Cough, year given: _____ Pneumonia, year given: _____ Shingles: _____

Other vaccines, year given: _____