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?

________________________________________________________________________
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: ________________________________