



Name _____

Date of Birth _____

Today's Date _____

Adult Health History Form

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control, herbs, etc.

| Medication | Dose (e.g., mg/pill) | How many times per day |
|------------|----------------------|------------------------|
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Allergies or reactions to medications: None _____

HEALTH MAINTENANCE SCREENING TESTS:

Sigmoidoscopy _____ or Colonoscopy _____ Date _____ Abnormal? Yes No

Women: Mammogram: Date _____ Abnormal? Yes No

Pap Smear: Date _____ Abnormal? Yes No

Dexascan (osteoporosis): Date _____ Abnormal? Yes No

Men: PSA (prostate): Date _____ Abnormal? Yes No

Last Eye Exam: Date _____

Last Dental Exam: Date _____

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems.

- Heart disease: _____ High blood pressure High cholesterol
- specify type _____ Diabetes Kidney disease
- Asthma/Lung disease Thyroid problems Cancer: (specify) _____
- Other: (specify) _____

SURGICAL HISTORY: Please list all prior operations (with dates):

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

- Alcoholism _____ High cholesterol _____
- Cancer, specify type _____ High blood pressure _____
- Heart disease _____ Stroke _____
- Depression/suicide _____ Bleeding or clotting disorder _____
- Genetic disorders _____ Asthma/COPD _____
- Diabetes _____ Other _____

WOMEN'S HEALTH HISTORY: # pregnancies _____ # deliveries _____ # abortions _____ # miscarriages _____

Age at start of periods _____ Age at end of periods _____

SOCIOECONOMICS: Occupation _____ Employer _____
Spouse/partner's name _____ Number of children/ages _____

SOCIAL HISTORY:

Tobacco Use

Cigarettes: Never Quit Date _____ Current Smoker: packs/day _____ # of years _____
Other Tobacco: Pipe Cigar Chew
Are you interested in quitting? No Yes

Alcohol Use

Do you drink alcohol? No Yes # drinks/week _____
Is your alcohol use a concern for you or others? No Yes

Drug Use

Do you use any recreational drugs? No Yes
Have you ever used needles to inject drugs? No Yes

EXERCISE:

Do you exercise regularly? No Yes
What kind of exercise? _____ How long (minutes) _____ How often _____
If you do not exercise, why not? _____

CAFFEINE INTAKE: None Coffee/tea/soda ____ cups/day

SAFETY:

Do you feel safe in your home? Yes No
Is violence at home a concern for you? Yes No
Have you ever been abused? Yes No

| Date Reviewed: | By (initials): |
|----------------|----------------|
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