Adult Health History

Date: _____

Name: _____ DOB: ___/__/____

Past Medical History: Please check any medical problems you've had and note the year.

____Acne
____Allergies: Type _____
____Anemia
____Asthma
____Back Problems
____Blood Transfusion
____Cancer: Type_____
____Depression
____Diabetes
____Drug Problems
____Alcohol Problems
____Anorexia
____Bulimia
____Gallbladder Problems
____Heart Disease
____Heart Attack
____Heart Murmur
____High Blood Pressure
____High Cholesterol
____Kidney Stones
____Liver Disease/Hepatitis
____Migraines
____Multiple Sclerosis
____Pre-cancerous Skin Lesions
____Rheumatic Heart Disease
____Seizures
____Stroke/TIA
____Suicide Attempt
____Thyroid Problems
____Ulcer

Other Major Medical Problems not listed
_____

Women Only:
# of Pregnancies ____ # of Deliveries ____
# of Miscarriages ____ # of Abortions ____
Last Menstrual Period (First Day) _____
Abnormal Pap Smear: Yes or No
Sexually Transmitted Disease: No or Yes: _____

Surgical History: Please list prior surgeries and dates:

_____
_____

Family History:

	IF LIVING		IF DECEASED	
	Age	Major Health Problems	Age of Death	Reason
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Sister	_____	_____	_____	_____

Social History:

Exercise: □ None □ 1-2/week □ 3-4x/week □ 5-7x/week

Marital Status: □ Married □ Widowed □ Divorced □ Single

Do you have children? Y or N If yes, how many? Girls: _____ Boys: _____

What is your religion? _____ What is your Primary Occupation: _____

Do you use tobacco? _____ Packs/Cans per day: _____ How Long? _____

Alcohol Use: □ None □ Occasional 1-2/week □ Moderate 3-5/week □ Heavy (>6/week)

Alcohol Consumed: □ Beer □ Wine □ Hard Liquor

Do you feel you need to quit or cut down? _____

Drug Use: □ Marijuana □ Cocaine □ Meth □ IV drugs □ Other _____

Name: _____ DOB: ___/__/____

Medication Allergies: _____

Reaction: _____

Other Allergies: _____

Medications*:* ***(including ALL over-the-counter meds, supplements, birth control, etc – may provide a separate list)***

DRUG:	**DOSE**:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Health Care Maintenance: *Please list date of last test/exam:*

Bloodwork: _____ Which test? *Select all that apply:* Cholesterol __ Diabetes __ Thyroid __ Anemia __ Other __
Colonoscopy: _____
Eye Exam: _____
Dental Exam: _____

Female: Mammogram: _____
Pap: _____

Male: Prostate Cancer Screen: _____

Immunizations*: (Yes or No, approx. date)*

- Hepatitis A: _____
- Hepatitis B: _____
- Flu: _____
- Covid: _____ Booster: _____
- Pneumonia: _____
- Tetanus Booster: _____

Sleep History:

- Do you snore? _____
- Has anyone told you that you stop breathing while you sleep? _____
- Do you fall asleep during meetings, while reading a book, or watching TV? _____
- How many hours per night do you sleep? _____
- Do you dream? _____ Do you have restless legs in the evening or at bedtime? _____
- Do you feel rested when you wake up? _____