Adult Health History

Date: ______________________________

Name: ____________________________________ Age:____Gender:____ Date of Birth:_______________

FAMILY HISTORY

Has any blood relative had any of the following or currently has any of the following:

	Yes	No		Yes	No
Asthma	___	___	High Cholesterol	___	___
Alcoholism	___	___	Diabetes	___	___
Emphysema	___	___	High Blood Pressure	___	___
Depression	___	___	Heart Disease	___	___
Cancer	___	___	Stroke	___	___
Seizures	___	___	Arthritis	___	___
TB	___	___	Allergies	___	___
Other (please list)	___	___			

____

PAST ILLNESSES

Have you had any of the following:

	Yes	No		Yes	No
Asthma	___	___	Emphysema	___	___
Depression	___	___	High Cholesterol	___	___
Cancer	___	___	Bowel Trouble	___	___
Gallstones	___	___	Drug Problem	___	___
High Blood Pressure	___	___	Allergies	___	___
TB	___	___	Heart Disease	___	___
Diabetes	___	___	Blood Disorder	___	___
Back Trouble	___	___	Liver Problems	___	___
Hearing Loss	___	___	Sexually Transmitted Disease	___	___
Skin Problems	___	___	Kidney Problems	___	___
Anxiety	___	___	Thyroid Disease	___	___
Stroke	___	___	Alcohol Problem	___	___
Glaucoma	___	___			

Hospitalizations

List year and reason for all times you have been hospitalized

_________	___________________________
_________	___________________________
_________	___________________________
_________	___________________________
_________	___________________________

Medicines

List all medications you are taking, including prescription and over-the-counter medicines

_________	___________________________
_________	___________________________
_________	___________________________
_________	___________________________
_________	___________________________

Allergies

Please check any allergies you have had and the reaction

		Reaction
___	Penicillin	______________
___	Sulfa	______________
___	Aspirin	______________
___	Codeine	______________
___	Bee Sting	______________
___	Food	______________
___	Other (list)	______________
___	No Known Drug Allergies	

Immunizations

Please check any immunizations you have had and the approximate year

Immunization	Year
___ Tetanus	______
___ Pneumovax	______
___ Hepatitis-B	______
___ Influenza	______
___ Other (list)________	______
________________	______
________________	______

Females Only

Age at first menstrual period ________

Number of times pregnant ________

Number of living children ________

Date of last Pap Smear ________

Age when periods stopped ________

Birth Control Method ________

When was your last mammography ________

Males Only

Date of last prostate exam ________

Date of last Prostate Screening ________

Birth Control Method ____________

Safety (Male and Female)

	Yes or	No
Do you always wear a seat belt?	___	___
Do you have guns in your house?	___	___
Do you have a smoke detector?	___	___
Do you wear a helmet if needed?	___	___

Nutrition/Dental (Male and Female)

	Yes or	No
Do you get regular dental check-up?	___	___
Do you watch your fat intake?	___	___
Are you on a special diet?	___	___

What type____________________________

Social History (Male and Female)

	Yes or	No
Do you exercise at least 3 times a week?	___	___
Do you smoke cigarettes?	___	___
How many per day?__________		
Is there a smoker in the home?	___	___
Do you smoke cigars?	___	___
How many per day?__________		
Do you chew tobacco?	___	___
How often?______________		
Do you drink alcohol?	___	___
How much?______________		
Have you ever felt guilty about your drinking?	___	___
Do you use drugs?	___	___
What drugs?____________________		
How much?______________________		
Have you ever been physically or sexually abused?	___	___

Personal History (Male and Female)

	Yes or	No
Are you satisfied with your sex life?	___	___
Feeling down or depressed?	___	___
Trouble sleeping?	___	___
Worried about weight?	___	___

Aids Risk (Male and Female)

	Yes or	No
Have you had more than 1 sexual partner in the past year?	___	___
Have you or your sexual partner ever used IV drugs?	___	___
Have any of your sexual partners had Aids or a positive HIV test?	___	___
Have you ever had a venereal disease (VD)?	___	___
Have you ever had a blood transfusion between 1979 and 1985?	___	___