Adult Health History Form

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Use Form for Ages 18 and Older

Adult's Personal Information

Patient Last Name: ______ First Name: ______ Middle Initial: ______

Date Of Birth: *(month/day/year)* ______ Age: ______

Previous Doctor? ______

Current Health Concerns: ______

List Current Medications (Including: Vitamins, Herbs, Supplements, and Birth Control)

Name / Dose / How Many Times Per Day?: ______

Current Allergies / Reactions to Medications?: ______

Major Health Problems / Hospitalizations / Operations / Broken Bones / Severe Pain Information

Please Describe any Major Health Problems and Related Dates: ______

Please List any Hospitalizations / Operations and Related Dates: ______

Please List any Broken Bones and / or Severe Pain: ______

Social / Personal History Information

Occupation: ______ Do You Exercise? ☐ Yes ☐ No

Have You Ever Smoked a Tobacco Product? If You Have Quit...Provide Date ______

Do You Drink Alcoholic Beverages? If Yes, How Often & How Much? ______

Do You Now or Have You Ever Used Drugs? If Yes, What Was It? ______

Immunization Information

Please bring immunizations records with you to the appointment if available.

Date of Last Tetanus Shot?		☐ Requesting One Today
Date of Last Pneumonia Shot?		☐ Requesting One Today
Date of Last Flue Shot?		☐ Requesting One Today
Date of Last Tuberculosis Test?		☐ Requesting One Today
Zostavax (Shingles Vaccine)?		☐ Requesting One Today
Hepatitis B Vaccine?		☐ Requesting One Today

Family History Information

Please check all that apply to your family history.

☐ Alcoholism / Drug Abuse	☐ Cancer: Breast	☐ Psychiatric Disorders
☐ Heart Disease / Attack / Stroke	☐ Cancer: Colon	☐ Depression / Suicide
☐ High Blood Pressure	☐ Cancer: Prostate	☐ Inherited / Genetic Diseases
☐ High Cholesterol	☐ Diabetes	☐ Thyroid Disease
Other: ______	Other: ______	Other: ______

Fall / Depression Risk Information

Do You Require the Assistance of Crutches, a Walker, or a Cane? ☐ Yes ☐ No

During the Past Month, Have You Been Bothered By:

Little Interest or Pleasure in Doing Things?	☐ Yes	☐ No
Feeling Down, Depressed, or Hopeless?	☐ Yes	☐ No
Having Thoughts about Harming Yourself or Someone Else?	☐ Yes	☐ No
Feeling Safe in Your Personal Relationships?	☐ Yes	☐ No

Women Only Information

Date of Last Menstrual Period? ☐

What is Your Current Method of Birth Control? ☐

Are You Interested in a Different Method? ☐ Yes ☐ No

Number of Pregnancies? ☐ Number of Living Children? ☐ Abortions / Miscarriages? ☐

Age of Menarche? ☐ At What Age Did Periods Stop? *(If Applicable)* ☐

Do You Leak Urine? ☐ Yes ☐ No

Date of Last Pap Smear? ☐ Have You Ever Had an Abnormal Pap Smear? ☐ Yes ☐ No

Date of Last Mamogram? ☐ Have You Ever Had an Abnormal Mamogram? ☐ Yes ☐ No

Have You Had a Bone Density Test? ☐ Yes ☐ No

Have You Had a Colonoscopy? ☐ Yes ☐ No

Men Only Information - Over the Last Month or so, How Often Have You:

Had a Sensation of Not Emptying Your Bladder Completely after You Finish Urinating?	☐ Yes	☐ No
Had to Urinate Again Less Than 2 Hours after Urinating?	☐ Yes	☐ No
Stopped and Started again Several Times when Urinating?	☐ Yes	☐ No
Found it Difficult to Delay Urinating?	☐ Yes	☐ No
Had to Push or Strain to Begin Urinating?	☐ Yes	☐ No
Wake Up at Night to Urinate?	☐ Yes	☐ No
Have You ever had a Prostrate Exam?	☐ Yes	☐ No
Have You ever had a Colonoscopy?	☐ Yes	☐ No
Have You ever had a Bone Density Test?	☐ Yes	☐ No
Have You had any Problems with Your Libido?	☐ Yes	☐ No

Men or Women - Have You Had any of These Problems Within the Last 6 Months:

Weight Loss / Gain, Skin Changes, Fatigue, Headaches, Depression, or Anxiety?	☐ Yes	☐ No
Head, Ears, Eyes, Nose, or Throat?	☐ Yes	☐ No
Heart or Chest Pain?	☐ Yes	☐ No
Kidneys, Bladder, or Urination?	☐ Yes	☐ No
Stomach or Intestinal Problems / Blood in Stool?	☐ Yes	☐ No
Breast Lumps / Discharge?	☐ Yes	☐ No
Have You had a New Sexual Partner Since Your Last Visit?	☐ Yes	☐ No
Do You have to be Tested for any Sexually Transmitted Diseases?	☐ Yes	☐ No
Within the Last Year, have You been Emotionally or Physically Abused?	☐ Yes	☐ No