Adult Health History

Name	Date of birth	Date

Your answers on this form will help your healthcare provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best answer. Thank you.

Main reason for today's visit

Other concerns

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor	Primary care provider

Review of Systems *Have you ever had any of the following (check all that apply)*

Neuro:
- □ Confusion
- □ Memory Loss
- □ Stroke
- □ Numbness/Tingling
- □ Disease:

____

Heart:
- □ Irregular
- □ Murmur
- □ Heart Attack
- □ CHF
- □ Pacemaker
- □ Edema
- □ CAD

Lungs:
- □ SOB
- □ COPD
- □ Asthma
- □ Coughing
- □ Sleep Apnea
- □ O2 Use

Skin:
- □ Wounds/ulcers
- □ Rashes
- □ Lesions
- □ Fragile Skin
- □ Bruises
- □ Varicose Veins

Back:
- □ Pain
- □ Injury
- □ History of Vertebral Fractures
- □ Surgery:

____

Vascular:
- □ History of Stents
- □ PAD – Peripheral Arterial Disease
- □ Varicose Veins

HEENT:
- □ Hard of Hearing
- □ Sinus Problems

Abdomen/GI:
- □ Tenderness
- □ Liver Disease
- □ Reflux/GERD

Mobility:
- □ History of Falls
- □ Uses Cane
- □ Uses Walker
- □ Uses Wheelchair

Other:
- □ Use of Osteoporosis medication
- □ History of Vertebral Fractures

In the past month have you had little interest or pleasure in doing things, or felt down, depressed or hopeless?

☐ Yes ☐ No

Do you have an Advanced Care Plan (Living Will)

☐ Yes ☐ No

Who is your surrogate decision maker?

Name: ☐ None

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Allergies *Do you have allergies or reactions to the following, please list*

Medications	Reaction	Foods	Reaction

Medication

Prescriptions and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication/Vitamin Supplement	Dose/Strength (e.g., mg/pill)	How Many Times Per Day	Medication/Vitamin Supplement	Dose/Strength (e.g., mg/pill)	How Many Times Per Day

Medical History			**Surgeries**		
Major illnesses: (i.e., high blood pressure, high cholesterol, depression, etc.)	Year of diagnosis	Doctor treating	Surgeries	Year of surgery	Reason for surgery
1.			1.		
2.			2.		
3.			3.		
4.			4.		
5.			5.		
6.			6.		
7.			7.		
8.			8.		
9.			9.		
10.			10.		

Adult Health History

Family History

Mother ☐ Living ☐ Deceased	Major Illnesses
Father ☐ Living ☐ Deceased	Major Illnesses
# brothers alive: ________________ # brothers deceased: ____________	Major Illnesses
# sisters alive: ________________ # sisters deceased: ____________	Major Illnesses
# children alive: ________________ # children deceased: ____________	Major Illnesses

Social History

Tobacco use

Cigarettes ☐ Never ☐ Quit date: ________________ ☐ Current smoker: _________ packs/day; # of years _______

Other tobacco; ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ Vape

Are you interested in quitting? ☐ Yes ☐ No

Alcohol use

Do you drink alcohol? ☐ Yes ☐ No # drinks/week _______________________

Is alcohol use a concern for you or others? ☐ Yes ☐ No

Are you satisfied with your weight? ☐ Yes ☐ No	How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Socioeconomics

Occupation

Employer

Marital status

☐ Single ☐ Partner/Married ☐ Divorced ☐ Widowed

Women Health History

# Pregnancies	# Deliveries	# Abortions	# Miscarriages

Exercise

Do you exercise regularly? ☐ Yes ☐ No	If you do not exercise, why not?	
If yes, what kind of exercise:	How long (minutes)	How often?

Signature

Patient signature	Date

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