

Medical Record #:	ecord #·	Medical Record #:
-------------------	----------	-------------------

ADULT PATIENT HEALTH HISTORY

This questionnaire will become a confidential part of your medical record. If you do not want to answer a question, leave it blank and discuss it privately with your doctor at your visit. Today's date: ____/___ Appt. date: ____/___ Primary Care Physician?____ Date of Birth: / / Name: ____ First Middle Last Patient signature: WHAT ARE THE MAIN REASONS FOR THIS VISIT? **PHYSICIAN'S COMMENTS** 2. _____ 3. _____ MEDICAL HISTORY Check major, significant illnesses which apply to you: ☐ Emotion/Mental illness Anemia ☐ Kidney disease EmphysemaEpilepsy/seizuresGlaucoma Asthma ☐ Kidney stones Liver disease Arthritis □ Bleeding/blood disorder □ Glaucoma Osteoporosis □ nay rever □ Rheumatic fever
□ Heart problems □ Stroke
□ Hepatitis/jaundice □ Thyroid disease
□ High blood pressure □ Tuberculosis/TB
□ HIV/AIDS □ Ulcers
Others: □ □ Breast cancer □ Cancer(s) Cataracts Colitis Depression Diabetes If a doctor has told you that you have a physical disability please describe:_____ **MEDICATIONS** List all medications you are currently taking which have been ordered by a doctor (including inhalers) and all over the counter drugs, vitamins or herbs. Please list prescribed medications first: Name of Medicine/Dose/Frequency: 1._____ 7.____ 13. ____ 8. 14. _____ 9. _____ 15. _____ 4. ______ 10. ____ 16. ____ 5. ______ 11. _____ 17. _____ 6. ______ 12. _____ 18. CHECK ANY ALLERGIES



☐ Medications List/Describe:

□ Food □ Animals □ Latex □ Tape □ Pollens □ Iodine □ Other:

Medical	Record #:	
IVICUICAL	NECUIU#.	

SURGICAL/HOSPITAL

PHYSICIAN'S COMMENTS

List the year of any Operations/Proced	·			
Year	Year			
Appendix surgery				
Breast growth removal Carpal Tunnel	Mana acceptant			
	Nia alla de la companya della companya della companya de la companya de la companya della compan			
Cataract surgery Cesarean section delivery				
Colonoscopy (looking into bowel)				
D & C	Duratata augustus			
Heart catheterization/surgery				
Hernia	Vasectomy			
Thyroid surgery Laparoscopy Thyroid surgery Lastroscopy (Looking into stomach) Tonsils/Adenoids removed Leart catheterization/surgery Tubal ligation Leart catheterization/surgery Tonsils/Adenoids removed Leart catheterization/surgery Label ligation Label ligati				
List any other Hospitalizations :	Year:			
What other doctors have you seen?				
	□ No			
List the cause of death for those who ha	ve dies prior to age 50 (Do not include accidental deaths):			
	d in a blood related brother (b), sister (s), mother (m), father (f), or			
grandparent (g):	Who			
	Who Who			
□ Alcoholism/Substance Abuse	= =			
□ Alzhiemers/Dementia				
□ Cancer (Breast)				
□ Cancer (Colon)	·			
□ Cancer (Prostate)				
□ Cancer (Other)	□ Tuberculosis			
□ Diabetes				
SOCIAL HISTORY				
Occupation:	Your Gender (Sex):			
Marital Status: □ Married □ Single □	□ Widowed □ Divorced If previously married, to whom:			
List your Ethnic Origin: ☐ Hispanic or La	itino □ Not Hispanic or Latino			
•	ka Native □ Asian □ Black/African American r Pacific Islander □ White (Caucasian) □ Other			
Please list number of children and year of Number of Sons Year of Births If you have minor children, do they live in	Number of Daughters Year of Births			

		Medical Reco	rd #:			
	LIFESTYLE					
1.	How many days per week do	o you exercise ? □ 0 □ 1-2 □ 3-	5 🗆 6-7			
	What do you do?:	How long do you exerc	ise?:			
2.	Do you follow a special diet	:? □ Yes □ No What diet?:				
3.	What is your Tobacco use?			r □ Past	□ Cu	ırrent
	a. Year quit:	b. Number of years used Tobacco:				
		mokeless □ Cigar □ Pipe □ Cig				
		of packs used/day:		7. W		NI.
4	e. Would you like help to qui			Yes		No
4.		holic drinks do you consume during one da	-	or - 12	□2	r mar
		. wine cooler, 5 oz. wine, 1.5 oz. liquor)		.er ⊔ 1-2 ∃1 □2 □		
	a. How many do you consu	•				
E	, ,	ou had a problem with drinking?		∃ Yes		No
5.		doctor for an issue related to drugs ?		Yes		No
6.	Do you need neip from your	doctor for a problem related to physical, ver		ntarabuse: TYes		No
7.	Over the last 2 weeks have	you lost pleasure in doing things or felt dow	_			
٠.		ral days □ More than half the days □ N			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
8.	Have you visited the dentist	•	earry every		es □	No
9.	Do you wear your seat belt?	•	ve 🗆 Sc	ometimes		
9. 10.	Check if either of these appl		ys 🗆 Sc	meumes	□ INE	vei
10.		e United States (other than vacation)/Military	, Sorvico	□ V (ac =	No
11.	Are you at risk for AIDS/HIV		y Service □ Yes	□ Unknov		
١١.		: ultiple sex partners, Needle drug use other tl			/VII 🗆	INO
12.		Yes □ No Have you had any falls in the l				Nο
13.		vities of daily living (personal hygiene, dress				NO
10.	☐ Yes ☐ No	vines of daily living (personal flygiene, dress	ing, caing	, mobility, c	ιο., .	
	HEALTH RISK					
	men Only:					
1.	Have you had a Pap Smear	within the <u>last 3 years</u> ?	Year	□ Y	'es 🗆	No
	a. Have you had an abnorma	al Pap Smear?		□Y	'es 🗆	No
2.	Do you usually do self breas	st exams?		□Y	'es 🗆	No
3.	Have you had a professiona	Il breast exam within the last 3 years?	Year		es 🗆	
4.	If 40 or above, have you had	d a mammogram within the last year?	Date	D	es 🗆	No
Me	n Age 50 or Older Only:					
5.	Have you had a prostate ex		Year	D Y	es 🗆	No
Ме	<u>n and Women Age 50 or Ol</u>					
6.		ecked for blood within the last year?	Year	D Y	es 🗆	No
7.		by (intestine exam) within the last 10 years?	Year	D Y	es 🗆	No
Мe	n and Women Age 60 or Ol					
8.	Have you had a zoster (shin		Year	□ Y	es 🗆	No
<u>Me</u>	<u>n and Women Age 65 or Ol</u>					
9.	,	·		□ Y		
	Have you had pneumonia sl			D		
	•	laucoma (high eye pressure) in the <u>last 2 ye</u>	<u>ars</u> ? Year	\ \ \ Y	es 🗆	No
	n and Women of All Ages:					
12.	Have you had a flu shot wit			\[\textsquare \textsquar		
13.		htheria shot within the <u>last 10years</u> ?		\[\textsquare \textsquar		
	•	, Mumps, Rubella shots or the diseases as a	a child?		'es 🗆	_
15.	Have you had the following	shots: Hepatitis A (Transmitted by food)			'es 🗆	No
		Hepatitis B (Transmitted by body se	ecretions)	□Y	es 🗆	No
16.	Have you had your choleste	erol checked within the last 5 years?	Year	🗆 Y	'es 🗆	No
			Result			
17.	Have you had your blood pr	essure checked within the last 2 years?		□Y	es 🗆	No

Medical Record #:_ Review of Symptoms Check any condition(s) which are **SIGNIFICANT PROBLEMS** to you: General Reproduction ☐ Recent 10 lb. weight change □ Blood in semen/sperm (men) □ Fevers (Frequent) ☐ Inability to have an erection (men) ☐ Frequent profound fatigue □ Inability to reach climax □ Frequent difficulty sleeping Infertility ☐ I have had a blood transfusion □ Painful intercourse Decreased sexual desire ☐ Sexually Transmitted Diseases **Head and Neck** □ Visual changes (Not glasses) Dizziness Women Double vision ☐ Breast pain/lumps (women) ☐ Pelvic pain (women) □ Sinus problems ☐ Frequent persistent nosebleeds □ Vaginal discharge (women) Ear pain □ Vaginal dryness (women) □ Trouble hearing ☐ Frequent sweats/hot flashes (women) ☐ Ringing in the ear ☐ Menstrual problems: Hoarseness Date of last period: □ Persistent sore throat Menopause ☐ Mouth sores □ Pregnancy problems ☐ Baby weighing 9 lbs or more ☐ Swollen glands (Frequent) Number of full term births (>36 wks) ___ Number of premature births (<36 wks) _____ Respiratory/Lungs □ Persistent cough Number of miscarriages/abortions □ Shortness of breath Number of living children ___ □ Coughing up blood Wheezing Skeletal ☐ Joint pain (major) Stop breathing during sleep □ Back pain (major) Heart/Vascular □ Neck pain (major) □ Chest pain/tightness □ Weakness in arms/legs □ Irregular rapid heart beat □ Joint swelling/stiffness ☐ Smothering feeling at night Deformities of the back/extremities □ Ankle swelling □ Gout Stomach/Bowel Neuro Major appetite change □ Numbness or tingling □ Nausea/Vomiting (Frequent) □ Severe frequent headaches ☐ Frequent heart burn/acid in throat (GERD) □ Abnormal coordination □ Abdominal pain ☐ Trouble with speech □ Diarrhea (Frequent) □ Forgetfulness/confusion Constipation □ Black/Bloody stools **Skin and Hair Problems** □ Vomiting blood ☐ Changes in hair/hair loss (major) □ Wounds that will not heal □ Difficulty swallowing □ Persistent rash Kidney/Bladder □ Change in moles □ Major skin problems ☐ Kidney/bladder infection Problem with bladder control □ Difficulty starting urination Psych/Social □ Frequent urination □ Feeling blue/discouraged ☐ High anxiety/stress Increased urgency ☐ Urination more than once nightly Loss of friends

☐ Burning or painful urination

□ Difficulty emptying bladder

□ Blood in the urine

☐ Feeling life has no purpose

□ Feeling fear□ Hearing voices

☐ Feeling others are talking about you

Marital or relationship problemsEarly morning awakenings