ADULT HEALTH HISTORY

Patient Name: _____ **Date of Birth:** _____

What is the reason for visit? _____

List any allergies (medication, environmental, food, etc.)	**Reaction**

List any medications you are taking (Including vitamins, herbs, diet pills, over the counter, and prescription)	**Dosage**	**Frequency**

What pharmacy do you use? _____

PERSONAL MEDICAL HISTORY

Abuse as Adult (Victim)	❑Yes ❑No	Depression	❑Yes ❑No	Liver disease	❑Yes ❑No
Abuse as Child (Victim)	❑Yes ❑No	Diabetes	❑Yes ❑No	Meningitis	❑Yes ❑No
Allergies	❑Yes ❑No	Emphysema/COPD	❑Yes ❑No	Myocardial Infarction	❑Yes ❑No
Anemia	❑Yes ❑No	GERD	❑Yes ❑No	Nerve/muscle disease	❑Yes ❑No
Anxiety	❑Yes ❑No	Glaucoma	❑Yes ❑No	Osteoporosis	❑Yes ❑No
Arthritis/Joint Disorder	❑Yes ❑No	Heart attack	❑Yes ❑No	Seizures	❑Yes ❑No
Asthma	❑Yes ❑No	Heart disease	❑Yes ❑No	Sickle Cell Anemia	❑Yes ❑No
Blood Transfusion	❑Yes ❑No	Heart failure	❑Yes ❑No	Stomach Ulcers	❑Yes ❑No
Cancer	❑Yes ❑No	Heart murmur	❑Yes ❑No	Stroke	❑Yes ❑No
What kind? _____		High Blood Pressure	❑Yes ❑No	Substance abuse	❑Yes ❑No
Cataracts	❑Yes ❑No	High Cholesterol	❑Yes ❑No	TB Disease	❑Yes ❑No
Clotting Disorder	❑Yes ❑No	HIV/AIDS	❑Yes ❑No	Thyroid disease	❑Yes ❑No
COPD	❑Yes ❑No	Kidney disease	❑Yes ❑No		

List any other health conditions: _____

WOMEN'S HEALTH HISTORY

Last Pap smear?_____ Were the results normal? ❑Yes ❑No History of abnormal pap smears? ❑Yes ❑No

Are you having regular periods? ❑Yes ❑No When was the first day of your last menstrual period? _____

Have you ever been pregnant? ❑Yes ❑No How many times have you been pregnant? _____

When was you last mammogram? _____

DES Exposure? ❑Yes ❑No

SURGICAL HISTORY

Appendectomy	❑Yes ❑No	C-Section	❑Yes ❑No	Small Intestine surgery	❑Yes ❑No
Brain surgery	❑Yes ❑No	Eye surgery	❑Yes ❑No	Spine surgery	❑Yes ❑No
Breast surgery	❑Yes ❑No	Fracture surgery	❑Yes ❑No	Third molar extraction	❑Yes ❑No
CABG	❑Yes ❑No	Gallbladder surgery	❑Yes ❑No	Tonsillectomy	❑Yes ❑No
Colon surgery	❑Yes ❑No	Heart surgery	❑Yes ❑No	Tubal ligation	❑Yes ❑No
Cosmetic surgery	❑Yes ❑No	Hernia repair	❑Yes ❑No	Valve Replacement	❑Yes ❑No
What kind? _____		Hysterectomy, Full	❑Yes ❑No	Vasectomy	❑Yes ❑No
		Joint replacement	❑Yes ❑No		

List any other surgeries you have had: _____

FAMILY HISTORY

❑ Family history unknown ❑ Adopted If cancer selected, what type of cancer? _____

Other family history: _____

Relationship	Alive?	Age	Alcohol / Drug Addiction	Cancer	Heart Problems	Diabetes	High Cholesterol	High Blood Pressure	Mental Health
Mother									
Father									
Sister									
Brother									
Daughter									
Son									

SOCIAL HISTORY

Tobacco Use Current every day smoker? ❑ Yes ❑ No Former use? ❑ Yes ❑ No Ready to quit? ❑ Yes ❑ No

Current some day smoker? ❑ Yes ❑ No

Type of tobacco used: ❑ Cigarettes ❑ Pipe ❑Cigars ❑E-cig ❑Snuff ❑Chew

How much of a pack do you currently or have you previously smoked per day? _____

How many years have you or did you smoke for? _____ What year did you quit? _____

Substance Use ❑ Yes ❑ Never ❑ Not currently

Type:

❑Amphetamines	❑Barbiturates	❑Benzodiazepines	❑Crack	❑Cocaine
❑Ecstasy	❑Hashish	❑Heroin	❑IV	❑ Ketamine
❑LSD	❑Marijuana	❑Mescaline	❑Methamphetamine	❑Nitrous Oxide
❑ Solvent inhalants	❑Opioids	❑PCP	❑ Prescription stimulants	❑Psilocybin
❑Vaping	❑Other: _____			

How do you use? ❑Smoke ❑Inject ❑Other:_____ How many times per week? _____

Alcohol Use ❑ Yes ❑ No ❑ Not currently

Number of drinks per week ____ Glasses of wine (5oz) ____ Cans of beer (12oz) ____ Shots of liquor (1.5oz)

Sexually Active ❑ Yes ❑ No ❑ Not currently

Partners: ❑ Men ❑ Women ❑ Both ❑ Transgender Female ❑ Transgender Male ❑ Other ❑ Choose not to disclose ❑ Non-Binary/genderqueer ❑ Questioning

Birth control: ❑Abstinence ❑ Birth Control Pill ❑ Patch ❑Cervical Cap ❑Condom ❑Diaphragm ❑Fertility Awareness ❑Implant ❑Injection ❑IUD ❑IUS ❑Menopause ❑Rhythm ❑Spermicide ❑Sponge ❑Surgical ❑Vaginal Ring ❑Vasectomy ❑Withdrawal ❑Other: _____

How many children do you have? _____

Lifestyle

Do you exercise? ❑ Yes ❑ No How many days per week?____ For how long (hours or minutes)? ____

Do you follow any specific diet? ❑ Yes ❑ No If yes, what kind? _____

Home Environment

Do you have a steady place to live? ❑Yes ❑Yes, but I am worried about losing it ❑No (temporary, homeless, shelter, other)

How often do you feel lonely? ❑Never ❑Rarely ❑Sometimes ❑Often ❑Always ❑Decline to answer

How much stress have you experienced in the last month? ❑None ❑A little bit ❑Somewhat ❑Quite a bit ❑Very much ❑Decline to answer

Do you have someone you can call for help? ❑ Yes ❑ No

Relationship Safety Because violence & abuse happens to a lot of people & it affects their health, we are asking the following:

How often does anyone, including family and friends:

Physically hurt you?	❑Never	❑Rarely	❑Sometimes	❑Fairly Often	❑Frequently
Insult or talk down to you?	❑Never	❑Rarely	❑Sometimes	❑Fairly Often	❑Frequently
Threaten or harm you?	❑Never	❑Rarely	❑Sometimes	❑Fairly Often	❑Frequently
Scream or curse at you?	❑Never	❑Rarely	❑Sometimes	❑Fairly Often	❑Frequently