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Integrated & Preventative
Health Care Associates PLC
Family Practice & Preventative Med

Name _____ Date _____

Adult Health History Form

Age _____ How would you rate your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Main reason for today's visit: _____

Other concerns: _____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional
- ____ Recent fevers/sweats
- ____ Unexplained weight loss/gain
- ____ Unexplained fatigue/weakness

Eyes
- ____ Change in vision

Ears/Nose/Throat/Mouth
- ____ Difficulty hearing/ringing in ears
- ____ Hay fever/allergies/congestion
- ____ Trouble swallowing

Cardiovascular
- ____ Chest pains/discomfort
- ____ Palpitations
- ____ Short of breath with exertion

Breast
- ____ Breast lump
- ____ Nipple discharge

Respiratory
- ____ Cough/wheeze
- ____ Coughing up blood

Gastrointestinal
- ____ Heartburn/reflux
- ____ Blood or change in bowel movement
- ____ Nausea/vomiting/diarrhea
- ____ Pain in abdomen

Genitourinary
- ____ Painful/bloody urination
- ____ Leaking urine
- ____ Nighttime urination
- ____ Discharge: penis or vagina
- ____ Unusual vaginal bleeding
- ____ Concern with sexual functions

Musculoskeletal
- ____ Muscle/joint pain
- ____ Recent back pain

Skin
- ____ Rash
- ____ New or change in mole

Neurological
- ____ Headaches
- ____ Memory loss
- ____ Fainting

Psychiatric
- ____ Anxiety/stress
- ____ Sleep problem

Blood/Lymphatic
- ____ Unexplained dumps
- ____ Easy bruising/bleeding

Endo
- ____ Cold/heat intolerance
- ____ Increase thirst/appetite

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? ❑ Yes ❑ No

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	Dose (e.g., mg/pill)	How many times per day

Allergies or reactions to medications: _____

Date of your most recent IMMUNIZATIONS:

Hepatitis A _____ Hepatitis B _____ Influenza (flu shot) _____ MMR _____ Pneumovax (pneumonia) _____

Meningitis _____ Tetanus (Td) _____ Varicella (chicken pox) shot or Illness _____ Tdap (tetanus & pertussis) _____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) _____ Date _____ Abnormal? ❑ Yes ❑ No

Sigmoidoscopy ____ or Colonoscopy _____ Date _____ Abnormal? ❑ Yes ❑ No

Women: Mammogram ____ Date _____ Abnormal? ❑ Yes ❑ No Pap Smear ____ Date ____ Abnormal? ❑ Yes ❑ No

Dexascan (osteporosis) ____ Date _____ Abnormal? ❑ Yes ❑ No

Men: PSA (prostate) _____ Date _____ Abnormal? ❑ Yes ❑ No

– OVER –

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates).

___ Heart disease: ___ High blood pressure ___ High cholesterol
specify type ___ Diabetes ___ Thyroid problem
___ Asthma/Lung disease ___ Other: (specify): ___ ___ Kidney disease
___ Cancer: (specify): ___

SURGICAL HISTORY: Please list all prior operations (with dates):

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism ___ High cholesterol ___
Cancer, specify type ___ High blood pressure ___
Heart disease ___ Stroke ___
Depression/suicide ___ Bleeding or clotting disorder ___
Genetic disorders ___ Asthma/COPD ___
Diabetes ___ Other: ___

SOCIAL HISTORY

Tobacco Use

Cigarettes ❑ Never ❑ Quit Date ___
❑ Current Smoker: packs/day ___ # of yrs ___
Other Tobacco: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew
Are you interested in quitting? ❑ No ❑ Yes

Alcohol Use

Do you drink alcohol? ❑ No ❑ Yes # drinks/week ___
Is your alcohol use a concern for you or others? ❑ No ❑ Yes

Drug Use

Do you use any recreational drugs? ❑ No ❑ Yes
Have you ever used needles to inject drugs? ❑ No ❑ Yes

Sexual Activity

Sexually active: ❑ Yes ❑ No ❑ Not currently
Current sex partner(s) is/are: ❑ male ❑ female
Birth control method: ___ ❑ None needed
Have you ever had any sexually transmitted diseases (STDs)?
❑ No ❑ Yes
Are you interested in being screened for sexually transmitted diseases? ❑ No ❑ Yes

OTHER CONCERNS

Caffeine Intake: ❑ None ❑ Coffee/tea/soda ___ cups/day
Weight: Are you satisfied with your weight? ❑ No ❑ Yes
Diet: How do you rate your diet? ❑ Good ❑ Fair ❑ Poor
Do you eat or drink four servings of dairy or soy daily or take calcium supplements? ❑ No ❑ Yes
Exercise: Do you exercise regularly? ❑ No ❑ Yes
What kind of exercise? ___
How long (minutes) ___ How often? ___
If you do not exercise, why? ___
Safety: Do you use a bike helmet? ❑ No ❑ Yes ❑ NA
Do you use seatbelts consistently? ❑ No ❑ Yes
Is violence at home a concern for you? ❑ Yes ❑ No
Have you ever been abused? ❑ Yes ❑ No
Do you have a gun in your home? ❑ Yes ❑ No

Have you completed a living will or or durable power of attorney for health care? ❑ Yes ❑ No

SOCIOECONOMICS Occupation: ___ Employer: ___

Years of education/highest degree: ___ Marital Status: Single Partner/Married Divorced Widowed Other: ___

Spouse/partner's name: ___ Number of children/ages: ___

Who lives at home with you? ___

WOMEN'S HEALTH HISTORY # pregnancies ___ # deliveries ___ # abortions ___ # miscarriages ___

Age at start of periods: ___ Age at end of periods: ___

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