Name: ______________________________
Computer Number: ______________________
Date of Birth: _________________________

ADULT HEALTH HISTORY

Date: ______________________________

Why are you here today?____

Medication Allergies?________________ If yes, please give name and describe reaction:___________________________

Current Medications (including birth control, over the counter meds, herbs, etc.):____________________________

____

Number of Sex Partners in the last year? ____________________ Sex of Your Partner(s): Male________ Female______

When was the last time you had sex? ________________ What are you using to prevent pregnancy? _________________

Total Number of Pregnancies:______________ Date of your **last** pregnancy **or** miscarriage/abortion:_________________

Premature Births:______________ # Abortions / Miscarriages:________________ # Living Children:________________

Are you Breastfeeding?________________________ First Day of Last Menstrual Period:___________________________

# of Days Menstrual Period lasted:_______________ Date of Last Pap: ________________ Was it Normal? ❑Yes ❑No

(Men Only) - Date of last Prostate Exam: _______________________________________ Was it Normal? ❑Yes ❑No

PLEASE SELECT THE BEST ANSWER:

Do you exercise daily? …………………………………………………………………… ❑Yes ❑No
Would you like to talk to someone about your diet? ………………………………… ❑Yes ❑No
Do you use seatbelts? …………………………………………………………………… ❑Yes ❑No
Do you drink alcohol? …………………………………………………………………… ❑Yes ❑No
If yes, how much and how often?____

Do you use drugs? ……………………………………………………………………… ❑Yes ❑No
If yes, what do you use? ______________________________ How often?_______________

Does your partner(s) use drugs? ………………………………………………………… ❑Yes ❑No
If yes, what does he/she use? __________________________ How often?_______________

Have you ever smoked? ………………………………………………………………… ❑Yes ❑No
Do you smoke now? …………………………………………………………………… ❑Yes ❑No
How much per day?____

Would you like to talk to someone about Smoking/Alcohol/Drug Problems that you, your family or partner may have?
……………………………………………………………………………………………… ❑Yes ❑No

Are you currently or have you ever been in a relationship where you are physically hurt, threatened or made to feel afraid?
……………………………………………………………………………………………… ❑Yes ❑No

Comments/Questions: ____

Have you ever had any of the following? If YES, please give date and explain.

Condition	Yes	No	DATE/EXPLAIN
ANEMIA	❑Yes	❑No	
GALLBLADDER DISEASE	❑Yes	❑No	
THYROID DISEASE	❑Yes	❑No	
ABNORMAL PAP SMEAR	❑Yes	❑No	
MAMMOGRAM	❑Yes	❑No	
BREAST PROBLEMS	❑Yes	❑No	
HIGH BLOOD PRESSURE	❑Yes	❑No	
SEVERE HEADACHES	❑Yes	❑No	
DIABETES	❑Yes	❑No	
BLOOD CLOTS IN LUNGS OR LEGS	❑Yes	❑No	
STROKE	❑Yes	❑No	
HEART DISEASE OR MURMUR	❑Yes	❑No	
SEXUALLY TRANSMITTED DISEASE	❑Yes	❑No	
TUBAL OR ECTOPIC PREGNANCY	❑Yes	❑No	
DEPRESSION OR NERVOUS DISEASE	❑Yes	❑No	
TUBERCULOSIS	❑Yes	❑No	

HEPATITIS OR LIVER DISEASE…………………………..	❑ Yes	❑ No	____________________
HIV TESTING OR COUNSELING……………………….	❑ Yes	❑ No	____________________
ULCERS……………………………………………………..	❑ Yes	❑ No	____________________
BLOOD IN URINE OR STOOL…………………………..	❑ Yes	❑ No	____________________
SEIZURES………………………………………………….	❑ Yes	❑ No	____________________
CANCER……………………………………………………..	❑ Yes	❑ No	____________________
TROUBLE WITH VISION OR HEARING……………….	❑ Yes	❑ No	____________________
OTHER………………………………………………………..	❑ Yes	❑ No	____________________

Have you ever been hospitalized or had surgery? ………………………………………………………………….. ❑ Yes ❑ No

DATE	**REASON**
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, when**?** ____________________

FAMILY HISTORY:

Does anyone in your family (blood relative) have any of the following? Please name your relationship with the relative you list and give their age. (**EXAMPLE**: Uncle/56 Yrs or Sister/25 Yrs or Father/65 Yrs)

THYROID DISEASE ____________	BREAST CANCER ____________
COLON CANCER ____________	OTHER CANCER (Specify) ____________
HEART ATTACK ____________	DIABETES OR SUGAR ____________
STROKE ____________	HIGH BLOOD PRESSURE ____________
DEPRESSION/MENTAL ILLNESS____________	TUBERCULOSIS____________
ALCOHOLISM ____________	ANEMIA OR LOW BLOOD____________
OTHER ____________	

Did your mother take hormones when she was pregnant with you (Born between 1938-1971)?.............................❑ Yes ❑ No

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I attest that everything here to the best of my knowledge is true and correct.

____________________ ____________________

Patient Signature Date

I have reviewed page 1 & 2 with the patient.

____________________ ____________________

Clinician Signature Date

HOW MAY WE CONTACT YOU:

❑ Mail…………………………………………..Current Address: ____________________
____

❑ Telephone………………………………Telephone Number: ____________________

❑ Other ____________________