Primary Care Health Partners

ADULT HEALTH HISTORY

(Use for ages 21 and over)

Your answers on this form will help your provider understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank You.**

Patient Name:_____ Today's Date: _____

Date of Birth: _____ Age: _____ How would you rate your general health? □ Excellent □ Good □ Fair □ Poor

Main reason for today's visit: _____

Other concerns I would like to discuss today: _____

REVIEW OF SYSTEMS Please check any CURRENT symptoms you have.

General
____ Recent fevers/sweats
____ Unexplained weight loss/gain
____ Unexplained tiredness/weakness

Eyes
____ Change in vision

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

Heart/Cardiovascular
____ Chest pains/discomfort
____ Palpitations
____ Short of breath with activity

Breast
____ Breast lump
____ Nipple discharge

Lungs/Respiratory
____ Cough/wheeze
____ Coughing up blood

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

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

Musculoskeletal
____ Muscle/joint pain
____ Recent back pain

Skin
____ Rash
____ New or change in mole

Neurological
____ Headaches
____ Memory loss
____ Fainting/falling

Psychiatric/Emotional
____ Anxiety/stress
____ Sleep problems

Blood/Lymph
____ Unexplained lumps
____ Easy bruising/bleeding

Endocrine
____ Cold/heat sensitive
____ Increased thirst/appetite

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

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CURRENT MEDICATIONS Please list **all** medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	Dose (mg/pill)	Times/day	Medication	Dose (mg/pill)	Times/day

ALLERGIES or reactions to medications: _____

Date of your most recent **IMMUNIZATIONS:** Influenza (flu shot) _____ Pneumovax (pneumonia) _____ Tetanus (Td) _____
Tdap (tetanus & pertussis) _____ Hepatitis A _____ Hepatitis B _____ MMR _____ Meningitis _____

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Patient Name:_____ Date:_____

PERSONAL MEDICAL HISTORY:

Please note if you have had any of the following medical problems

_____ Heart disease:
Specify type:_____
_____ Heart attack
_____ Asthma/lung disease

_____ High blood pressure
_____ Diabetes
_____ Cancer (type)_____
_____ Other (specify)_____

_____ High cholesterol
_____ Thyroid problem
_____ Kidney disease
_____ Birth defects

SURGICAL HISTORY:

Please list all prior operations (with dates)

_____

FAMILY HISTORY:

Please note family members (mother, father, sister, brother, aunt, uncle, grandparent)

Alcoholism _____
Cancer (type) _____
Heart disease _____
Depression/suicide _____
Genetic disorders _____
Diabetes _____

High cholesterol _____
High blood pressure _____
Stroke _____
Bleeding/clotting disorder _____
Asthma/COPD _____
Other _____

SOCIAL HISTORY:

Tobacco use: □ Never □ Quit date: _____
□ Current smoker: packs/day____ # of years____
Other tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Plan to quit? □ Now □ Sometime later □ No/never

Alcohol use:
Do you or any household members drink alcohol?
□ No □ If Yes, who? _____ □ Socially
drinks/week_____

Drug Use/Addiction:
Do you or any household members use illegal drugs?
□ No □ If Yes, who? _____
Name of drug? _____
Does anyone in your household have an addiction to a drug or prescription medication?
□ No □ If Yes, who? _____
Name of drug/medication _____

OTHER CONCERNS:

Caffeine Use: □ 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
Exercise: Do you exercise regularly? □ No □ Yes, how often? _____
What kind of exercise? _____ Minutes per day? _____
If you do not exercise, why? _____
Safety: Do you use a bike/motorcycle helmet? □ NA □ No □ Yes
Do you regularly wear seatbelts? □ No □ Yes
Is there violence in the home? □ No □ Yes
Have you ever been abused? □ No □ Yes
Do you have a gun in your home? □ No □ Yes
Sexual Activity:
Sexually active? □ No □ Yes □ Not currently
Current sex partner(s) is/are: □ Male □ Female
Birth control method _____ □ None needed
Have you ever had any sexually transmitted diseases? (STD's) □ No □ Yes, _____
Interested in being screened for STD's? □ No □ Yes

Do you have a completed living will or power of attorney for health care? □ No □ Yes

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HEALTH MAINTENANCE/SCREENING TESTS:

General: Yearly dental visits? □ No □ Yes Date of last dental checkup? _____ □ Unknown

Do you take Calcium? □ No □ Yes Do you take Aspirin? □ No □ Yes

Have you had any of the following tests? Select each box that applies and enter date and result of most recent test.

	□ lipid (cholesterol) test	Date: _____	Abnormal? □ No □ Yes
	□ Sigmoidoscopy or □ Colonoscopy	Date: _____	Abnormal? □ No □ Yes
	□ Stool for occult blood (3 samples)	Date: _____	Abnormal? □ No □ Yes
Men:	□ PSA (prostate)	Date: _____	Abnormal? □ No □ Yes
Women:	□ Mammogram	Date: _____	Abnormal? □ No □ Yes
	□ Clinical breast exam	Date: _____	Abnormal? □ No □ Yes
	□ Pap smear	Date: _____	Abnormal? □ No □ Yes
	□ Dexascan/bone density	Date: _____	Abnormal? □ No □ Yes

Age at start of periods: _____ First day of last menstrual period: _____ Age at end of periods: _____

Do you have problems with your period or birth control? □ No □ Yes, _____

List number of pregnancies: _____ Deliveries: _____ Abortions/miscarriages: _____ Living children/ages: _____

If post menopause or over age 50, do you take:

Calcium? □ No □ Yes Estrogen? □ No □ Yes Progesterone? □ No □ Yes

SOCIAL/ECONOMIC:

Occupation: _____ Employer: _____

Highest year of education: _____ Marital status: □ Single □ Married/partnered □ Divorced □ Widowed □ Other

Spouse/Partner's name: _____ Number of children (ages): _____

Who lives at home with you? _____

Signature of person completing this form: _____