

Adult Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best answer. **Thank you!**

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

Main reason for today's visit: _____

Other concerns: _____

Allergies or reactions to medications: _____

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

<input type="checkbox"/> Heart disease: specify type _____	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High cholesterol
<input type="checkbox"/> Asthma/Lung disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid problem
	<input type="checkbox"/> Other: (specify) _____	<input type="checkbox"/> Kidney disease
	<input type="checkbox"/> Other: (specify) _____	<input type="checkbox"/> Cancer: (specify) : _____
	<input type="checkbox"/> Other: (specify) _____	

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

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

<i>Constitutional</i>	<i>Respiratory</i>	<i>Skin</i>
<input type="checkbox"/> Recent fevers/sweats	<input type="checkbox"/> Cough/wheeze	<input type="checkbox"/> Rash
<input type="checkbox"/> Unexplained weight loss/gain	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> New or change in mole
<input type="checkbox"/> Unexplained fatigue/weakness		
<i>Eyes</i>	<i>Gastrointestinal</i>	<i>Neurological</i>
<input type="checkbox"/> Change in vision	<input type="checkbox"/> Heartburn/reflux	<input type="checkbox"/> Headaches
	<input type="checkbox"/> Blood or change in bowel movement	<input type="checkbox"/> Memory loss
<i>Ears/Nose/Throat/Mouth</i>	<input type="checkbox"/> Nausea/vomiting/diarrhea	<input type="checkbox"/> Fainting
<input type="checkbox"/> Difficulty hearing/ringing in ears	<input type="checkbox"/> Pain in abdomen	
<input type="checkbox"/> Hay fever/allergies/congestion	<input type="checkbox"/> Constipation	<i>Psychiatric</i>
<input type="checkbox"/> Trouble swallowing		<input type="checkbox"/> Anxiety/stress
	<i>Genitourinary</i>	<input type="checkbox"/> Sleep problem
<i>Cardiovascular</i>	<input type="checkbox"/> Painful/bloody urination	
<input type="checkbox"/> Chest pains/discomfort	<input type="checkbox"/> Leaking urine	<i>Blood/Lymphatic</i>
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Nighttime urination	<input type="checkbox"/> Unexplained lumps
<input type="checkbox"/> Short of breath with exertion	<input type="checkbox"/> Discharge: penis or vagina	<input type="checkbox"/> Easy bruising/bleeding
	<input type="checkbox"/> Unusual vaginal bleeding	
	<input type="checkbox"/> Concern with sexual functions	<i>Endocrine</i>
<i>Breast</i>		<input type="checkbox"/> Cold/heat intolerance
<input type="checkbox"/> Breast lump	<i>Musculoskeletal</i>	<input type="checkbox"/> Increase thirst/appetite
<input type="checkbox"/> Nipple discharge	<input type="checkbox"/> Muscle/joint pain	
	<input type="checkbox"/> Recent back pain	

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

Medication	Dose	Frequency	Medication	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

HEALTH MAINTENANCE SCREENING TESTS:

Sigmoidoscopy _____ or Colonoscopy _____ Date _____ Abnormal? Yes No

Women: Mammogram _____ Date _____ Abnormal? Yes No

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:

Cancer, specify type: _____ Bleeding or clotting disorder: _____

Heart disease: _____ Other: _____

Genetic disorders: _____

SOCIAL HISTORY

Tobacco Use

Cigarettes Never Quit Date _____ Current Smoker: packs/day _____ # of yrs _____

Other Tobacco: Pipe Cigar Snuff Chew

Alcohol Use

Do you drink alcohol? No Yes # drink/week _____

Drug Use

Do you use any recreational drugs? No Yes

I certify that, to the best of my knowledge, the above information is accurate.

Signature Date

Reviewed with patient by:

Edward Medina, M.D. Date

