Adult Health History Form
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SUCCESSFUL HEALTH CARE IS ONLY POSSIBLE WHEN THE PROVIDER HAS A COMPLETE UNDERSTANDING OF THE PERSON PHYSICALLY, MENTALLY AND EMOTIONALLY.

PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE.

PLEASE, PRINT AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

Name _____ Date _____

Age _____ Date of Birth _____ Gender Identity_____

Address_____ City_____ State____ Zip _____

Phone #'s _____

E-mail address _____

Person(s) to reach in an emergency _____

Relationship(s) _____ Phone #'s_____

Is any other family member already seeing me? _____

May I thank someone for referring you to me? _____

Are you hypersensitive or allergic to:
Any drugs? _____
Any foods? _____
Any environmental things? _____

Do you use tobacco, currently? ☐ Y ☐ N Smoked previously? ☐ Y ☐ N
How many years? _____
How many packs per day? _____

Are you currently receiving healthcare for any reason? ☐ Yes ☐ No
If yes, from whom? _____

For what reason(s)? _____

Do you have a primary care doctor or other health care providers you see regularly, for any reason? Please list:

_____

Do you have a diagnosed illness or disease that we should list as a part of your health history?

_____

What are your top FIVE most important health problems or goals, in order of importance.

1) _____

2) _____

3) _____

4) _____

5) _____

Current Medications/Supplements/Herbs/Homeopathics:

Please list ALL <u>vitamins, herbs, supplements AND</u> prescription medications OR over the counter medications you are taking, regularly.
Please include ingredients, milligram amounts, how often taken, etc.
For multi-ingredient products, PLEASE BRING IN THE BOTTLES OR CLEAR PHOTOS OF THE FRONT AND BACK LABELS, so I may see the detail.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Height _____Weight today _____ lbs.

Maximum weight _____ lbs. When? _____

Weight one year ago? _____lbs.

Desired weight _____lbs.

CANCER PATIENTS, ONLY

What surgeries have you had for your condition and when?

_____

_____

Have you had or are you now receiving any chemotherapy (oral or IV) or immunotherapy treatment? If yes, which drugs, how many cycles, when was your last treatment, etc.?

_____

_____

_____

Have you had any radiation treatments of any type? Which body part(s)? Approximately how many treatments and when?

_____

_____

FOR ALL OTHER CONDITIONS

What surgeries have you had and when?

_____

When have you been hospitalized and what for?

_____

SOCIAL HISTORY

Are you: ☐ Single ☐ Married ☐ Divorced ☐ in a Significant Partnership ☐ Widowed

DO YOU Live: Alone ☐ w/Spouse ☐ w/Children ☐ w/Partner ☐ w/Parent(s) ☐ w/ Roommates

Occupation _____

Hours per week _____ Retired? _____

Employer _____

In a typical week, how many times do you talk in person on the telephone with family, friends, or neighbors?

_____

In a typical week, how often do you get together with friends, relatives, or neighbors?

_____

Do you belong to any social organizations, groups, churches, spiritual groups or practices?

_____

Main interests and hobbies: _____

SCREENINGS:

Date of last Physical Exam? _____ Colonoscopy? _____ Labs? _____
Males: Prostate Exam? _____
Females: Last PAP smear or pelvic exam? _____ Last mammogram? _____

FAMILY HISTORY

Please note if any of these disease/problems are/were applicable to your parents, grandparents, uncles, aunts, siblings or children. Please note for whom it was a problem.
Cancer & Type
Diabetes
Heart Disease
High Blood Pressure
Strokes
Mental Illness

Are your parents, grandparents, siblings and children all still living? _____
If not, please note their cause of death and at what age(s), if known?

_____

Typical Food Intake- Examples

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

EXERCISE

Do you exercise? ☐YES ☐ NO
If yes, what type? _____
How often do you exercise? _____How many minutes per week? _____

For the following sections, please use this key:

Y= a condition you have now N= a condition you have never had P= had in the past

Do you average 7-8 hours of sleep?	☐Y ☐N	Do you enjoy your work?	☐Y ☐N ☐ P
Sleep well?	☐Y ☐N	Take vacations?	☐Y ☐N ☐ P
Awaken rested?	☐Y ☐N	Spend time outside?	☐Y ☐N
Have a supportive relationship?	☐Y ☐N	Do you watch television?	☐Y ☐N

Y= a condition you have now N= a condition you have never had P= had in the past

Have a history of any abuse? ☐ Y ☐ N
Any major traumas? ☐ Y ☐ N
Do you eat 3 or more meals/day? ☐ Y ☐ N
Do you eat out, often (4x/week+)? ☐ Y ☐ N
Do you go on diets, often? ☐ Y ☐ N
Do you drink any coffee? ☐ Y ☐ N
Do you drink black tea? ☐ Y ☐ N
Do you add salt to your food? ☐ Y ☐ N

For TV, how many hours/day? _____
Do you read, regularly? ☐ Y ☐ N
How many hours/day? _____
Use alcoholic beverages? ☐ Y ☐ N ☐ P
How much, how often? _____
Treated for alcoholism/drug addiction? ☐ Y ☐ N
Do you drink cola or other sodas/soft drinks? ☐ Y ☐ N
How many hrs./day for "Screen time"? _____

Sexual orientation _____
Are you, currently, having sex with a partner? ☐ Y ☐ N
Any sexual difficulties? _____
Birth control used? _____
Do you have children? Please list names, sex, and ages.
_____

Do you travel often for work? ☐ Y ☐ N
Any remote locations or 3rd world countries? _____
Are you exposed to any chemicals of occupational hazards as a part of your day or work?
_____

Do you have any pets? If so, please list type _____

HEAD

Do you have chronic headaches, migraines, a head injury history, TMJ problems, etc.? PLEASE LIST
_____

EYES

Do you have impaired vision, visual disturbances, eye pain, "dry eye syndrome", excessive tearing glaucoma, cataracts, macular degeneration, etc.? PLEASE LIST
_____

EARS

Do you have impaired heating, ringing in your ears (tinnitus), ear pain, etc.? PLEASE LIST
_____

NOSE AND SINUSES

Do you suffer from frequent colds or sinus infections, nose bleeds, loss of smell, etc.? PLEASE LIST
_____

MOUTH AND THROAT

Do you have any issues with frequent sore throat/mouth/lips/tongue; hoarseness, teeth grinding, gum problems, dental problems, etc.? PLEASE LIST
_____

SEASONAL ALLERGIES

Do you have any chronic, seasonal allergy symptoms? What are your symptoms? PLEASE LIST

_____

RESPIRATORY

Do you have any issues with a chronic cough, asthma, wheezing, shortness of breath? PLEASE LIST

_____

Have you had pneumonia or bronchitis, recently?

_____

Have you been told you have COPD?

_____

Do you have a Tuberculosis history?

_____

CARDIOVASCULAR

Do you have a history of high cholesterol, heart attacks, blood clots, high blood pressure, chest pain, valvular problems, arrythmias, palpitations, etc.? PLEASE LIST

_____

BLOOD/PERIPHERAL VASCULAR

Do you have excessive bruising, easy bleeding, circulation problems, chronic anemia, etc.? PLEASE LIST

_____

GASTROINTESTINAL

Do you have any trouble with swallowing, nausea, vomiting, heartburn/acid reflux/GERD; an ulcer history, excessive bloating, burping, flatulence; hemorrhoids, liver disease, etc.? PLEASE LIST

_____

HOW OFTEN DO YOU HAVE A BOWEL MOVEMENT? _____

Are your stools well formed, hard, painful, loose, diarrhea or difficult to pass?

_____

Do you have a lot of straining or pass any blood or mucus with bowel movements?

_____

BONES/BACK/NECK/JOINTS/MUSCLES

Do you have problems with joint pain, stiffness, arthritis, muscle cramps, muscle spasms, back pain, neck pain, etc.? PLEASE LIST _____

Have you had a bone density scan? _____ If yes, when was the last one? _____

Do you have osteopenia or osteoporosis? _____

NEUROLOGY

Do you have a history of seizures, loss of consciousness, memory issues, muscle weakness, numbness or tingling; paralysis, vertigo/dizziness, neurological disorders? PLEASE LIST

_____

SKIN

Do you have issues with rashes, hives, eczema, acne, recurrent boils, unusual skin lesions or moles; hair loss? PLEASE LIST

_____

ENDOCRINE

Do you have hyper or hypothyroidism, diabetes Type I or II, pituitary problems, etc.? PLEASE LIST

_____

IMMUNE

Do you have a history of frequent infections, negative reactions to vaccinations, slow wound healing, etc.?

_____

URINARY/KIDNEY

Do you have pain with urination, inability to hold your urine, urinary frequency, frequent infections, a history of kidney stones; kidney disease, etc.? PLEASE LIST

_____

MALE REPRODUCTIVE SYSTEM

Do you have a history of hernias, testicular problems, prostates problems, sexually transmitted diseases?

_____

FEMALE REPRODUCTIVE SYSTEM

Age of first period? _____
Age/date of last period? _____
Day 1 of period to Day 1 of next period = _____days?
Are periods/cycles regular? ☐ Y ☐ N
Duration of bleeding for period? _____days
Painful periods? ☐ Y ☐ N
Heavy or excessive flow? ☐ Y ☐ N
PMS symptoms? ☐ Y ☐ N
If yes, what are your symptoms?
_____
Endometriosis history? ☐ Y ☐ N
Ovarian cyst history? ☐ Y ☐ N
Fibroid tumors ☐ Y ☐ N

Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Abnormal PAP history? ☐ Y ☐ N
Cervical dysplasia? ☐ Y ☐ N ☐ P
Sexually transmitted infections? ☐ Y ☐ N ☐ P
Please list_____
Gynecological surgeries/procedures?
_____
Menopausal symptoms? ☐ Y ☐ N
Please list _____
Do you perform breast self-exams? ☐ Y ☐ N
Breast pain/tenderness/nipple discharge? ☐ Y ☐ N

MENTAL/ EMOTIONAL/PSYCHOLOGICAL

Do you have a diagnosed, mental health disorder?

_____

Do you have mood swings, depression, anxiety, get easily stressed?

_____

Have you ever considered or attempted suicide? _____ When? _____

FINANCES

Describe your difficulty paying for basics like food, housing, medical care, and utilities.

- ○ Very hard
- ○ Hard
- ○ Somewhat hard
- ○ Not very hard

VIOLENCE

Within the last year, have you been humiliated or abused by your partner or ex-partner? _____
Within the last year, have you been afraid of your partner or ex-partner? _____
Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner? _____
Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner? _____

How do your current health conditions affect you?

_____

_____

What do you feel needs to happen for you to feel better?

_____

_____

What do you enjoy most in your life? _____

_____

How much change are you willing to make, currently, to improve your health?

MINIMAL? ☐ SOME? ☐ COMPLETE? ☐

Is there anything else you would like to add?

_____

_____

_____

Welcome!

We are glad to serve you!