Adult Patient History (ages 18 and older)

Name: _____ Chart#: _____

Date of Birth: _____ Occupation_____
List any work or environmental exposures to hazardous agents (radiation, chemicals, etc.)
_____
Marital Status: □Single □Married □Divorced □Widowed
Do you follow a particular diet? □Yes □No
If yes, what type of diet? □Vegan □Vegetarian □Low Carb □Paleo □_____
Do you have an exercise routine? _____ How many times a week do you exercise? _____
What type of exercise? _____
Do you use any drugs? (Marijuana, Speed, Heroin, Methadone, Ecstasy, Cocaine, etc.) □Yes □No
If yes, how often & how much? _____
Do you currently use any tobacco products? □Yes □No
What type of tobacco? □Cigarettes □Cigars □Smokeless
Do you have a history of tobacco use? □Yes □No
If yes, for how long? What type of tobacco? When did you quit? _____
Do you drink alcohol? □Yes □No, If yes, what type? □Beer □Wine □Liquor
How much and how often? _____
Do you drink caffeine? □Yes □No
If yes, how often & how much? _____
Are you sexually active? □Yes □No How many partners have you had? _____
Are you monogamous? □Yes □No Are you □Heterosexual □Homosexual □Bisexual?
Are you at risk for HIV? □Yes □No
Have you had a blood transfusion? □Yes □No, If yes, date _____
When was your last TB skin test? _____Tetanus Shot? _____
When was your last Colonoscopy? _____

Please list any other physicians or specialists from whom you receive care.

_____ _____
_____ _____
_____ _____

Please list medications which you are taking. Include vitamins, birth control pills, supplements, and non-prescription medications. Include name, strength and directions for each medication.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies - Please list any medication, food, pet, etc. to which you are allergic and the reaction you have:
Medications:

_____

_____

Food & Environmental:

_____

_____

Hospitalizations/Surgeries/Injuries/Accidents - Please list any of these that apply and include dates.

_____

_____

_____

_____

_____

_____

Please check any of these diseases/problems which you have had.

□ Alcoholism	□ Diabetes	□ Seizures
□ Anemia	□ Drug Addiction	□ Stomach Problems
□ Bladder/Kidney Problems	□ Heart Problems	□ Trouble with Hearing
□ Breathing Problems/Asthma	□ High Blood Pressure	□ Trouble with Vision
□ Bowel Problems	□ Hepatitis	□ Chronic Vaginal Infections
□ Cancer	□ Joint/Muscle Problems	□ Thyroid Disorder
□ Chicken Pox	□ Migraines	□ _____
□ Dizzy spells	□ Skin Problems	□ _____

Family History-☐Please check here if you are adopted.
Please consider the following conditions when completing this section. If a condition is not listed please add it to the appropriate family member's history.
Allergies, Arthritis, Asthma, Cancer, Diabetes, Heart Disease, High Blood Pressure, Migraines, Osteoporosis, Seizures, Stroke, and Substance Abuse

Mother: □ alive & well / □ deceased/age_____
Health Conditions _____
Father: □ alive & well / □ deceased/age_____
Health Conditions _____
Sibling #1: age _____ □ Male/□ Female, □ Alive & Well / □ Deceased/age_____
Health Conditions _____
Sibling #2: age _____ □ Male/□ Female, □ Alive & Well / □ Deceased/age_____
Health Conditions _____
Sibling #3: age _____ □ Male/□ Female, □ Alive & Well / □ Deceased/age_____
Health Conditions _____
Sibling #4: age _____ □ Male/□ Female, □ Alive & Well / □ Deceased/age_____
Health Conditions _____

For Females Only

How old were you when you had your first period? _____
When was the first day of your last period? _____
Do you ever miss periods? _____
Do you perform regular self-breast exams? _____
Date of last Mammogram _____ Where was it done? _____
Date of last Pap Smear _____ Where was it done? _____
Have you ever had an abnormal Pap Smear?_____ When? _____
Have you ever been pregnant? _____. If yes, how many times? _____
Number of Abortions _____ Miscarriages _____ Stillbirths _____ Twins _____
List Children here
1 – Date of Birth_____ □ Male/□ Female, □ Alive & Well/□ Deceased/age_____
2 – Date of Birth_____ □ Male/□ Female, □ Alive & Well/□ Deceased/age_____
3 – Date of Birth_____ □ Male/□ Female, □ Alive & Well/□ Deceased/age_____
4 – Date of Birth_____ □ Male/□ Female, □ Alive & Well/□ Deceased/age_____
5 – Date of Birth_____ □ Male/□ Female, □ Alive & Well/□ Deceased/age_____

For Males Only

Do you perform regular self-testicular exams? _____
Do you wake up in the middle of the night to urinate? _____
When was your last PSA test (screening for Prostate Cancer)? _____

Please tell us about any other health history that you think we should know about.

_____
_____
_____
_____
_____
_____

Provider Notes – (office use only)

_____
_____
_____
_____
_____
_____
_____
_____