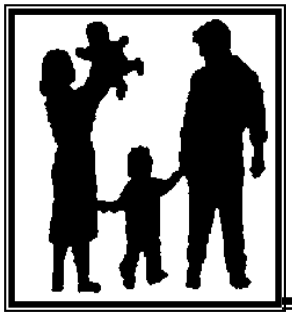

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Adult Health History Form

Name _____

Date _____

Associates in Primary Care Medicine, Inc

Your answers on this form will help your health provider better understand your medical concerns and conditions better. This form will not be put directly into your medical chart. If you are uncomfortable with any questions, do not answer it. If you cannot remember specific details, please provide your best guess. **Thank you!**

Age_____ How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Main reason for today's visit: _____

Other concerns: _____

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

Constitutional
_____ Recent fevers/sweats
_____ Unexplained weight loss/gain
_____ Unexplained fatigue/weakness

Eyes
_____ Change in vision

Ears/Nose/Throat/Mouth
_____ Difficulty hearing/ringing in ears
_____ Hay fever/allergies/congestion
_____ Trouble swallowing

Cardiovascular
_____ Chest pains/discomfort
_____ Palpitations
_____ Short of breath with exertion

Breast
_____ Breast lump
_____ Nipple discharge

Respiratory
_____Cough
_____Coughing up blood

Gastrointestinal
_____Heartburn/reflux
_____Blood or change in bowel movement
_____Nausea/vomiting/diarrhea
_____Pain in abdomen

Genitourinary
_____Painful/bloody urination
_____Leaking urine
_____Nighttime urination
_____Discharge: penis or vagina
_____Unusual vaginal bleeding
_____Concern with sexual functions

Musculoskeletal
_____Muscle/joint pain
_____Recent back pain

Skin
_____Rash
_____New or change in mole

Neurological
_____ Headaches
_____ Memory loss
_____ Fainting

Psychiatric
_____ Anxiety/stress
_____ Sleep problem

Blood/Lymphatic
_____ Unexplained lumps
_____ Easy bruising/bleeding

Endo
_____ Cold/heat intolerance
_____ Increase thirst/appetite

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

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

Medication	Dose (e.g., mg/pill)	How many times per day

Allergies or reactions to medications: _____

Date of your most recent **IMMUNIZATIONS:**

Hepatitis A _____ Hepatitis B _____ Influenza (Flu Shot) _____ MMR _____ Pneumovax (Pneumonia) _____
Meningitis_____ Tetanus (Td) _____ Varicella (Chicken Pox) shot or illness _____ Tdap (Tetanus & Pertussis) _____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (Cholesterol): Date _____ Abnormal? ☐ Yes ☐ No
Sigmoidoscopy or Colonoscopy _____ Date _____ Abnormal? ☐ Yes ☐ No
Mammogram (Women): Date_____ Abnormal? ☐ Yes ☐ No Pap Smear: Date _____ Abnormal? ☐ Yes ☐ No
Dexascan (Osteoporosis): Date _____ Abnormal? ☐ Yes ☐ No PSA (Men): Date _____ Abnormal? ☐ Yes ☐ No

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

_____ Heart disease:
(Specify)_____
_____ Asthma/Lung disease
_____High Blood Pressure
_____Diabetes
_____Other: (Specify): _____
_____ High Cholesterol
_____ Thyroid Problem
_____ Kidney Disease
Cancer: (Specify) _____

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

_____

FAMILY HISTORY: Please indicate the current status of your immediate family members
Please indicate family members (parents, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism_____ High Cholesterol _____
Cancer (Specify type)_____ High Blood Pressure_____
Heart Disease_____ Stroke _____
Depression/Suicide_____ Bleeding or Clotting Disorder_____
Genetic Disorders _____ Asthma/COPD_____
Diabetes _____ Other _____

SOCIAL HISTORY

Tobacco Use
Cigarettes: ☐ Yes ☐ No ☐ Quit (Date): _____
Current Smoker: Packs/Day: _____ # of Yrs: _____
Other Tobacco: ☐ Pipe ☐ Cigar ☐ Sniff ☐ Chew
Are you interested in quitting: ☐ Yes ☐ No

Alcohol Use
Do you drink alcohol: ☐ No ☐ Yes
If yes, # of drinks/week: _____
Is your alcohol use a concern for you or others: ☐ Yes ☐ No

Drug Use
Do you use any recreational drugs: ☐ Yes ☐ No
Have you ever used needles to inject drugs: ☐ Yes ☐ No

Sexual Activity
Sexually active: ☐ Yes ☐ No ☐ Not currently
Current Sex partner(s) is/are: ☐ Male ☐ Female
Birth control method: _____ ☐ None needed
Have you ever had any sexually transmitted diseases (STD):
☐ No ☐ Yes ☐ N/A
Are you interested in being screened for sexually transmitted diseases: ☐ No ☐ Yes ☐ N/A

OTHER CONCERNS

Caffeine Intake: ☐ None ☐ Coffee/Tea/Soda
Cups/Day: _____
Weight: Are you satisfied with your weight: ☐ Good ☐ Fair ☐ Poor
Diet: How do you rate your diet: ☐ Good ☐ Fair ☐ Poor
Do you eat or drink four servings of dairy/soy daily or take calcium supplements: ☐ Yes ☐ No
Exercise: Do you exercise: ☐ Yes ☐ No
What kind of exercise:_____
How long: _____How often: _____
If you do not exercise, why:
_____
_____

Safety: Do you use a bike helmet: ☐ No ☐ Yes ☐ N/A
Do you use seatbelts constantly: ☐ No ☐ Yes ☐ N/A
Is violence at home a concern to you: ☐ No ☐ Yes ☐ N/A
Have you ever been abused: ☐ No ☐ Yes ☐ N/A
Do you have a gun in your home: ☐ No ☐ Yes ☐ N/A

Have you completed a living will or durable power of attorney for healthcare? ☐ No ☐ Yes ☐ N/A

SOCIOECONOMICS
Occupation: _____ Employer: _____
Martial Status: ☐ Single ☐ Partner/Married ☐ Divorced ☐ Widowed ☐ Other: _____
Years of education/highest degree: _____
Spouse/Partner's name: _____
Who lives at home with you: _____

WOMEN'S HEALTH HISTORY
# of Pregnancies _____ # of Deliveries _____ # of Abortions _____ # of Miscarriages _____
Age at start of periods:_____ Age at end of periods: _____