Adult History

All questions contained in the questionnaire will be kept strictly confidential.

Patient's Name: ______________________________Date of Birth :______________________

ALLERGIES:

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1.	
2.	
3.	
4.	

PAST MEDICAL HISTORY

[ ] Acid Reflux Disease (or GERD)
[ ] Anxiety
[ ] Allergies
[ ] Attention Deficit Disorder (ADD or ADHD)
[ ] Asthma
[ ] Arthritis
[ ] Birth Defect
[ ] Bleeding Disorder
[ ] Blood Clots (or DVT)
[ ] Cancer
[ ] Birth Defect

[ ] Bleeding
[ ] Chronic Pain
[ ] Congestive Heart Failure
[ ] Depression
[ ] Blood Clots (or DVT)
[ ]Gout
[ ] Heart Attack
[ ] Heart Murmur
[ ] High Cholesterol
[ ] Pacemaker
[ ] Seizures
[ ] Stroke

[ ] HIV
[ ] Major Back Problems
[ ] Diabetes
[ ] Diverticulitis
[ ] Kidney DiseaseStone
[ ] Liver Disease
[ ] Dialysis
[ ]Hypertension
[ ]Hypothyroid (low thyroid)
[ ] Tuberculosis
[ ] Osteoporosis

Any other problems not listed above: ____

MEDICATIONS:

List all medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**.**

DRUG NAME	STRENGTH	FREQUENCY TAKEN (ie, once a day)
1.		
2.		
3.		
4.		

Adult History

FAMILY HEALTH HISTORY:

(Indicate with an "X" which family member has a history of which illness.)

	Mom	Dad	Brother(s)	Sister(s)
Diabetes				
Heart Disease				
High Blood Pressure				
Psychiatric Disease				
Cancer (type)				

Other family health history that you think your physician should consider important information concerning your health (such as children with heart problems or genetic conditions):

____

SOCIAL HISTORY:

Do you smoke? [ ] YES [ ] NO
How much? ________ Packs per day
How many years? __________
If you smoked in the past, when did you quit? ________________

How often do you drink alcohol? [ ] Never [ ] Occasionally [ ] Daily

Have you ever used recreational or street drugs? [ ] Yes [ ] No

Do you have any risk factors for HIV? [ ] Yes [ ] No (Examples include: IV drug use, multiple sex partners, past/present homosexual lifestyle, or blood transfusion prior to 1992)

Is God, religion, or prayer important to you?
[ ] Not very much [ ] Somewhat [ ] Quite a bit [ ] A great deal

What Church/group do you attend? ___________________________________

Adult History

PAST SURGICAL HISTORY:

SURGERY REASON YEAR HOSPITAL SURGEON

1.____
2.____
3.____

Other hospitalizations?
____

YOUR CARE TEAM:

List doctors you see regularly and their specialty:
Doctor____Specialty________________

Doctor____Specialty________________

Doctor____Speciality________________

OTHER:

Please add any other information about your health that you would like your provider to know here:
____
____
____

Thank you for completing this form