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.

ALLERGIES WITH REACTION:

1._____
2._____
3._____
4._____

PAST MEDICAL HISTORY:

[ ] Acid Reflux Disease (or GERD)
[ ] Anxiety
[ ] Allergies
[ ] Attention Deficit (ADD/ADHD)
[ ] Asthma
[ ] Arthritis
[ ] Birth Defect
[ ] Bleeding Disorder
[ ] Blood Clots (DVT)
[ ] Cancer
[ ] Chronic Pain
[ ] Congestive Heart Failure
[ ] Depression
[ ] Gout
[ ] Heart Attack
[ ] Heart Murmur
[ ] High Cholesterol
[ ] Pacemaker
[ ] Seizures
[ ] Stroke
[ ] HIV
[ ] Major Back Problems
[ ] Diabetes
[ ] Diverticulitis
[ ] Kidney Disease
[ ] Kidney Stones
[ ] Liver Disease
[ ] Dialysis
[ ] Hypertension
[ ] Hypotension
[ ] Hyperthyroid
[ ] 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

	DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.			
2.			
3.			
4.			

If you have additional medications, please add on back of this form or a separate sheet of paper

ADULT HISTORY

FAMILY HEALTH HISTORY:

(indicate with "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)				

PLEASE LIST BELOW ANY OTHER FAMILY HISTORY THAT YOU THINK YOUR PHYSICIAN SHOULD CONSIER IMPORTANT INFORMATION CONCERNING YOUR HEALTH (SUCH AS CHILDREN WITH HEART PROBLEMS OR GENETIC CONDITIONS)

_____

SOCIAL HISTORY:

Do you smoke? [ ] YES [ ] NO If yes, how much? _____ Packs per day

How many years have you smoked? _____ If you have 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

If yes, please list: _____

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

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

ADULT HISTORY

PAST SURGICAL HISTORY:

SURGERY	REASON	YEAR	HOSPITAL	SURGEON

ANY OTHER HOSPITLIZATIONS?

YOUR CARE TEAM: LIST ANY DOCTORS YOU SEE REGULARY AND THEIR SPECIALITY:

DOCTOR NAME: _____ SPECIALITY:_____

DOCTOR NAME: _____ SPECIALITY:_____

DOCTOR NAME: _____ SPECIALITY:_____

DOCTOR NAME: _____ SPECIALITY:_____

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

Thank you for completing this form