Todays date:

Adult Health History

Last Name:________________ Name:________________ Prior Last Name:________________

Name that you prefer to be called:________________ Date of Birth:________________

☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Other:__________

General

1. Are you ☐ Single ☐ Married ☐ Partnered ☐ Divorced or Separated ☐ Widowed
2. Where did you grow up? ____________
3. What kind of work do you do or, if retired, what did you do? ____________
4. What level of education did you complete?____________
5. When was the last time you were seen by a Primary Care Provider?____________
6. Do you have an Advance Directive or Living Will? ☐ Yes ☐ No
7. Do you have a POLST (Physician Order for Life Sustaining Treatment)? ☐ Yes ☐ No

Allergies

8. Have you ever had an allergic reaction to a medication/injection or anything else?

☐ No, I am not allergic to any medications and have no other allergies.

If yes, please write the names of the medications/injections first and then all other allergies.

Allergy	What Happens?

Medications

Please include all non-prescription drugs, vitamins and supplements

☐ None

Name of Medication/Vitamin/Supplement/Herbal	Frequency	Dose

*If you have more medications, please continue on the back of the page.

Medical History

9. Chronic Problems ☐ None

Problem	Number of Years	Additional Information

10. Last Colonoscopy: ____________________ ☐ None
11. Last Pap Smear: ____________________ ☐ None
12. Past History of Surgeries or Hospitalizations ☐ None

Year	Operation/Reason	Hospital

13. Family History ☐ Adopted ☐ Unknown

Relationship	Name	Deceased?	Any Health Issues?

14. Other Physicians and Providers of Health Care ☐ None

Name	Type of Physician/Provider	Reason for Care

Social History

15. Have you ever smoked cigarettes, cigar, smoke pipe, used snuff, or chewed tobacco?

☐ No ☐ Yes, please answer the questions below.

☐ Cigarettes (packs a day): How many years? Date quit?
☐ Cigar (number a day): How many years? Date quit?
☐ Pipe (number a day): How many years? Date quit?
☐ Snuff (number a day): How many years? Date quit?
☐ Chew (number a day): How many years? Date quit?

16. Do you drink alcohol? ☐No ☐ Yes, please answer the questions below

☐ Wine (glasses a week) How many years? Date quit?

☐ Beer (bottle or cans a week): How many years? Date quit?

☐ Liquor (shots a week?): How many years? Date quit?

17. Do you use marijuana? ☐ No ☐ Yes, please answer the questions below

☐ Smoking (grams a week): How many years? Date quit?

☐ Edibles (mg a week): How many years? Date quit?

☐ Other: How many years? Date quit?

18. Do you use other substances? ☐ No ☐ Yes, please answer the questions below.

Used within the last week? ☐ No ☐ Yes, how many times?:

Type of substances used: What type do you use? *Check all that apply*

☐ Methamphetamines ☐ Cocaine ☐ Heroin ☐ Other:

How many years? Date quit?

19. Do you have sex with ☐ Men ☐ Women ☐ Both ☐ I don't have sex

If you use birth control, what type do you use? *Check all that apply*

☐ Coitus interruptus (withdrawal or pullout method) ☐Condom

☐ Diaphragm ☐Nexplanon ☐ Depo-Provera ☐ IUD

☐ Birth Control Pills ☐ Patch ☐ Vasectomy

☐ Post-menopausal ☐ Tubal Ligation ☐ Other

20. Exercise: Do you exercise 2 or more days a week? ☐ Yes ☐ No

21. Anything else we should know?

Adult Review of Systems

Constitution ☐ All negative

Activity change	Yes	No
Appetite change	Yes	No
Chills	Yes	No
Excessive sweating	Yes	No
Fatigue	Yes	No
Fever	Yes	No
Unexpected weight change	Yes	No

Head & ENT ☐ All negative

Congestion	Yes	No
Dental problems	Yes	No
Drooling	Yes	No
Ear discharge	Yes	No
Ear pain	Yes	No
Facial swelling	Yes	No
Hearing loss	Yes	No
Mouth sores	Yes	No
Nose bleeds	Yes	No
Postnasal drip	Yes	No
Sinus pain	Yes	No
Sneezing	Yes	No
Sore throat	Yes	No
Tinnitus	Yes	No
Trouble swallowing	Yes	No
Voice changes	Yes	No
Runny nose	Yes	No
Sinus pressure	Yes	No

Eyes ☐ All negative

Eye discharge	Yes	No
Eye itching	Yes	No
Eye pain	Yes	No
Eye redness	Yes	No
Light intolerance	Yes	No
Visual disturbance	Yes	No

Respiratory ☐ All negative

Apnea	Yes	No
Chest tightness	Yes	No
Choking	Yes	No
Cough	Yes	No
Shortness of breath	Yes	No
Stridor	Yes	No
Wheezing	Yes	No

Cardiovascular ☐ All negative

Chest pain	Yes	No
Leg swelling	Yes	No
Palpitations	Yes	No

Gastrointestinal ☐ All negative

Abdominal distention	Yes	No
Abdominal pain	Yes	No
Anal bleeding	Yes	No
Blood in stool	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Rectal pain	Yes	No
Vomiting	Yes	No
Nausea	Yes	No

Endocrine ☐ All negative

Cold intolerance	Yes	No
Heat intolerance	Yes	No
Excessive thirst	Yes	No
Excessive hunger	Yes	No
Excessive urination	Yes	No

Genitourinary ☐ All negative

Difficulty urinating	Yes	No
Painful sexual intercourse	Yes	No
Painful urination	Yes	No
Bed wetting	Yes	No
Flank pain	Yes	No
Frequency	Yes	No
Genital Sore	Yes	No
Blood in urine	Yes	No
Menstrual problem	Yes	No
Pelvic pain	Yes	No
Urgency	Yes	No
Urine decreased	Yes	No
Penile discharge	Yes	No
Penile swelling	Yes	No
Testicular pain	Yes	No
Vaginal bleeding	Yes	No
Vaginal discharge	Yes	No
Vaginal pain	Yes	No
Scrotal swelling	Yes	No

Muscular ☐ All negative

Joint pain	Yes	No
Back pain	Yes	No
Gait problem	Yes	No
Joint swelling	Yes	No
Muscle pain	Yes	No
Neck pain	Yes	No
Neck stiffness	Yes	No

Skin ☐ All negative

Color change	Yes	No
Pallor	Yes	No
Rash	Yes	No
Wound	Yes	No

Allergy/Immuno ☐ All negative

Environmental allergies	Yes	No
Food allergies	Yes	No
Immunocompromised	Yes	No

Neurological ☐ All negative

Dizziness	Yes	No
Facial asymmetry	Yes	No
Headaches	Yes	No
Light headedness	Yes	No
Numbness	Yes	No
Seizures	Yes	No
Speech difficulty	Yes	No
Fainting	Yes	No
Tremors	Yes	No
Weakness	Yes	No

Hematologic ☐ All negative

Swollen lymph nodes	Yes	No
Bruises or bleeds easily	Yes	No

Psychiatric ☐ All negative

Agitation	Yes	No
Behavioral problems	Yes	No
Confusion	Yes	No
Decreased concentration	Yes	No
Hallucinations	Yes	No
Hyperactive	Yes	No
Nervous/Anxious	Yes	No
Self-injury	Yes	No
Sleep disturbance	Yes	No
Suicidal thoughts	Yes	No
Depression	Yes	No