ADULT HISTORY

Help Us Help You

This HEALTH HISTORY is an important step in making quality health care available to you and your family. Please answer the questions below. This information will be kept confidential and used for your continuing care.

(PLEASE PRINT)

Date _____

Patient's name _____ Birthdate _____

Person completing this history _____ Date of last complete physical exam _____

As an adult, list your:

1. Height _____ **2.** Highest weight _____ lbs. **3.** Lowest weight _____ lbs. **4.** Present weight _____ lbs.

MEDICAL HISTORY:

Have you ever had or do you now have any of the problems listed below?

	YES	NO		YES	NO		YES	NO	
5.	☐	☐	AIDS	☐	☐	Depression	☐	☐	Mononucleosis
6.	☐	☐	Anemia (Low Blood)	☐	☐	Epilepsy	☐	☐	Phlebitis (Blood Clot in Veins)
7.	☐	☐	Other blood disorder	☐	☐	Eye disease	☐	☐	Sexually transmitted disease (Gonorrhea, Herpes, Syphilis)
8.	☐	☐	Arthritis/Rheumatism	☐	☐	Gall bladder disease	☐	☐	Sickle Cell
9.	☐	☐	Asthma	☐	☐	Gout	☐	☐	Sinus
10.	☐	☐	Back trouble	☐	☐	Heart trouble	☐	☐	Stroke
11.	☐	☐	Bleeding tendencies	☐	☐	Hepatitis/Jaundice	☐	☐	Stomach trouble/Ulcers
12.	☐	☐	Bronchitis/Pneumonia	☐	☐	Hemorrhoids	☐	☐	Thyroid problems
13.	☐	☐	Emphysema	☐	☐	Hernia	☐	☐	German measles (Rubella)
14.	☐	☐	Cancer/Tumor	☐	☐	High blood pressure	☐	☐	Tuberculosis
15.	☐	☐	Colitis/Bowel problems	☐	☐	Hypoglycemia	☐	☐	Have you ever had a positive TB test?
16.	☐	☐	Convulsions (Seizures)	☐	☐	Kidney/Bladder trouble			If yes, when? _____
17.	☐	☐	Diabetes (Sugar)	☐	☐	Migraine headaches	**42.**		Year of last Tetanus shot _____

43. List any surgery (operations) _____

44. List any allergic reactions or sensitivities to medicine _____

_____

45. List any medications you are currently taking _____

_____

Have you had trouble with:

	YES	NO		YES	NO		YES	NO	
46.	☐	☐	Allergies	☐	☐	Chronic cough	☐	☐	Bowel problems (Such as)
47.	☐	☐	Abdominal pain	☐	☐	Coughing up blood	☐	☐	Constipation
48.	☐	☐	Vision	☐	☐	Chest pain	☐	☐	Diarrhea
49.	☐	☐	Hearing	☐	☐	Sleeping	☐	☐	Change in bowel habits
50.	☐	☐	Excessive bleeding	☐	☐	Dizziness/Fainting	☐	☐	Rectal bleeding
51.	☐	☐	Headaches	☐	☐	Fatigue/Tiredness	☐	☐	Heartburn/Indigestion
52.	☐	☐	Shortness of breath	☐	☐	Confusion/Loss of memory	☐	☐	Numbness/Tingling