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Adult Patient Health History

Please complete both sides of form

This questionnaire is used to collect information about your current health history. In addition to providing your health care team with important clinical information, this questionnaire also helps us meet special requirements established by Medicare and other health insurers.

Patient Information:

Name: _____ Date of Birth: _____/_____/____Birthplace: _____

Religion: _____ (If you choose to disclose) Gender at Birth: □Male □Female

What is your primary language? _____

Primary Care/Family Physician's Name: _____

City: _____

Allergies:

Have you had hives, skin rash, breathing problems or other allergic reactions to medications? □Yes □No

If yes, please list below:

Name of medicine(s): _____
Describe allergic reaction:

_____

Are there medications, other than those you are allergic to, you would prefer not to take due to prior unpleasant side effects? □Yes □No If yes, please specify:

_____

Have you had allergic reaction to:

- Iodine or x-ray contrast dye? □Yes □No
- Latex or rubber (gloves, condoms, balloons)? □Yes □No
- Shellfish? □Yes □No
- Bee or wasp stings? □Yes □No
- Adhesive tape? □Yes □No
- Other allergies (specify): _____
- List any food allergies: □None

  _____

Height: _____ Weight: _____ Date of last Flu shot: _____/_____/_____

Recent weight change? □No □Yes Gain of _____ lbs. Loss of _____lbs.

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Past Medical history:

Check if you have or have had any of the following:

- ◻ Allergies
- ◻ Cerebrovascular accident
- ◻ Hypertension
- ◻ Anemia
- ◻ COPD
- ◻ Irritable bowel disease
- ◻ Angina
- ◻ Coronary artery disease
- ◻ Migraine headaches
- ◻ Arthritis
- ◻ Depression
- ◻ Anxiety
- ◻ Myocardial infarction
- ◻ Asthma
- ◻ Diabetes
- ◻ Osteoarthritis
- ◻ Atrial fibrillation
- ◻ Gallbladder disease
- ◻ Osteoporosis
- ◻ Benign prostatic hypertrophy
- ◻ GERD
- ◻ Peptic ulcer disease
- ◻ Blood clots
- ◻ Hepatitis C
- ◻ Renal disease
- ◻ Cancer
- ◻ Hyperlipidemia
- ◻ Chron's disease
- ◻ Liver disease
- ◻ Seizure disorder (type:_____)
- ◻ Thyroid disease
- ◻ Other (specify):_____

Past surgical history:

Please check all that applies:

	Year		Year		Year
☐ Angioplasty	_____	☐ Colectomy	_____	☐ Pacemaker	_____
☐ Angio with Stent	_____	☐ Colostomy	_____	☐ Prostate Biopsy	_____
☐ Appendectomy	_____	☐ Gastric Bypass	_____	☐ Small Bowel Resection	_____
☐ Arthroscopy	_____	☐ Hernia Repair	_____	☐ Thyroidectomy	_____
☐ Back Surgery	_____	☐ Hip Replacement	_____	☐ Tonsillectomy	_____
☐ CABG	_____	☐ Knee Replacement	_____	☐ TURP	_____
☐ Carpal Tunnel	_____	☐ LASIK	_____	☐ Vasectomy	_____
☐ Cataract Extraction	_____	☐ Liver Biopsy	_____	☐ Other: _____	_____
☐ Cholecystectomy	_____	☐ ORIF	_____	☐ Other: _____	_____

Hospitalizations: Please list past major hospitalizations:

Year:	Place:	Illness/Injury Doctor:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Exercise:

□Yes □No How often do you exercise?_____

What type of exercise (walking, running, swimming)? _____

Coffee:

Do you drink coffee? □Yes □No How many cups of coffee do you drink in a day? _____

Tobacco:

Do you currently use tobacco? □Yes □No How many years have you used tobacco regularly? _____

What form of tobacco do you currently use? (cigarettes, pipe, cigar, chew)? _____

Do you use any other nicotine products (e-cigarette, vape pen, hookah)? □ Yes □ No

What form of other products? _____

How much tobacco do you use each day? _____ Have you used tobacco in the past? □Yes □No

Ever tried to quit? □Yes □No

Alcohol:

Do you drink alcohol? □Yes □No

What type of alcohol? _____ How much do you drink in a usual week? _____

When did you last drink? _____ When did you quit drinking? _____

How many times in the past year have you had 4+ drinks in a day if you're a woman, or 5+ drinks in a day if you're a man? _____

Substance Use:

In the past 12 months, hoe often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal Meth), hallucinogens, ecstasy/MMDA? □ Yes □ No

(Circle One): Daily or almost daily, weekly, monthly, less than monthly, or never.

Please list the following information about your family:

	Year of birth:	Major Illness (if applicable, cause of death)	Living/Deceased	If deceased, what age?
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings:	Gender	_____	_____	_____
_____	□M □F	_____	_____	_____
_____	□M □F	_____	_____	_____
Children:	Gender			
_____	□M □F	_____	_____	_____
_____	□M □F	_____	_____	_____

Family History:

Please check if any family members have had any of the following and who in the family had it. (Example: Allergies: Mother)

□Allergies_____
□Cancer _____
□High blood pressure
_____
□Alcoholism _____
□Diabetes _____
□Kidney disease _____
□Asthma _____
□Epilepsy _____
□Mental Health disorder

_____
□Bleeding tendency _____
□Heart disease _____
□Tuberculosis
_____
□Blindness _____

□Hearing loss
_____
□Stroke/CVA

_____
□Neurological disorder

_____

□Other (specify)
_____
_____

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Please list the following information about your family:

	Father	Mother	Siblings	Children
Year of birth			◻M ◻F ◻M ◻F ◻M ◻F ◻M ◻F	◻M ◻F ◻M ◻F ◻M ◻F ◻M ◻F
Major Illness				
Living/Deceased				
If deceased, what age?				
(if applicable, cause of death)				

Please list below all the medications you are currently taking and who prescribed it:

Medications:	Prescribing Doctor:	Date: