



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.

Past Medical history:

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

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

Past surgical history:

Please check all that applies:

- | | Year | | Year | | Year |
|--|-------|---|-------|--|-------|
| <input type="checkbox"/> Angioplasty | _____ | <input type="checkbox"/> Colectomy | _____ | <input type="checkbox"/> Pacemaker | _____ |
| <input type="checkbox"/> Angio with Stent | _____ | <input type="checkbox"/> Colostomy | _____ | <input type="checkbox"/> Prostate Biopsy | _____ |
| <input type="checkbox"/> Appendectomy | _____ | <input type="checkbox"/> Gastric Bypass | _____ | <input type="checkbox"/> Small Bowel Resection | _____ |
| <input type="checkbox"/> Arthroscopy | _____ | <input type="checkbox"/> Hernia Repair | _____ | <input type="checkbox"/> Thyroidectomy | _____ |
| <input type="checkbox"/> Back Surgery | _____ | <input type="checkbox"/> Hip Replacement | _____ | <input type="checkbox"/> Tonsillectomy | _____ |
| <input type="checkbox"/> CABG | _____ | <input type="checkbox"/> Knee Replacement | _____ | <input type="checkbox"/> TURP | _____ |
| <input type="checkbox"/> Carpal Tunnel | _____ | <input type="checkbox"/> LASIK | _____ | <input type="checkbox"/> Vasectomy | _____ |
| <input type="checkbox"/> Cataract Extraction | _____ | <input type="checkbox"/> Liver Biopsy | _____ | <input type="checkbox"/> Other: _____ | _____ |
| <input type="checkbox"/> Cholecystectomy | _____ | <input type="checkbox"/> ORIF | _____ | <input type="checkbox"/> Other: _____ | _____ |

Hospitalizations: Please list past major hospitalizations:

<u>Year:</u>	<u>Place:</u>	<u>Illness/Injury Doctor:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



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, how 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:

<u>Year of birth:</u>	<u>Major Illness (if applicable, cause of death)</u>	<u>Living/Deceased</u>	<u>If deceased, what age?</u>
Father _____	_____	_____	_____
Mother _____	_____	_____	_____
Siblings: <u>Gender</u>	_____	_____	_____
_____ <input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____
_____ <input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____
Children: <u>Gender</u>	_____	_____	_____
_____ <input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____
_____ <input type="checkbox"/> M <input type="checkbox"/> 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)

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies _____ | _____ | _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Bleeding tendency _____ | <input type="checkbox"/> Neurological disorder _____ |
| <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Heart disease _____ | _____ |
| _____ | <input type="checkbox"/> Tuberculosis _____ | _____ |
| <input type="checkbox"/> Alcoholism _____ | _____ | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Blindness _____ | _____ |
| <input type="checkbox"/> Kidney disease _____ | _____ | _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hearing loss _____ | _____ |
| <input type="checkbox"/> Epilepsy _____ | _____ | _____ |
| <input type="checkbox"/> Mental Health disorder _____ | <input type="checkbox"/> Stroke/CVA _____ | _____ |

Please list the following information about your family:

	Father	Mother	Siblings	Children
Year of birth			<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> 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:
