Adult Health History for New Patient

Name: ________________________________ **Birth Date:** ______________ **Today's Date:** ____________

Preferred Pharmacy (name and location): ____

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please fill out all pages. If you cannot remember specific details, please provide your best guess.

Medications

Please list all prescription and non-prescription medications, vitamins, and any supplements that you take, even on a non-regular basis.

Medication	Dosage	Times per day

Allergies

Please list all allergies to medications, latex, shellfish or iodine.

Allergies	Known Side Effects or Reactions

Personal Medical History

Condition	Current	Past	Comments
Alcohol/Drug Abuse			
Allergies (Hay fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid/Osteo)			
Asthma			
Bladder/Kidney Problems			
Blood Clot (Leg/Lung)			
Blood Transfusion			
Breast Lump (Benign)			
Cancer (Please List Type)			
Cataracts			
Chicken Pox			
Colon Polyps			
Coronary Artery Disease			
Depression			
Diabetes			
Diverticulitis			
Emphysema			
Fractures (Broken Bones)			
Gallbladder Disease			
GERD/Heartburn			
Glaucoma			
Gout			
Gynecological (Endometriosis)			
Gynecological (Fibroids)			
Gynecological (Other)			
Heart Attack			
Hepatitis (A, B or C)			
High Blood Pressure			
High Cholesterol			
Irritable Bowel Syndrome			
Kidney Disease/Failure			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate (Enlargement/Nodules)			
Seizure/Epilepsy			
Skin Conditions			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid Disease			
Other:			
Other:			
Other:			

Health Maintenance Screening Tests

For Females:	Mammogram	Date: ________________	Normal / Abnormal
	Pap Smear	Date: ________________	Normal / Abnormal
	Bone Density	Date: ________________	Normal / Abnormal
	Lipid Panel (Cholesterol)	Date: ________________	Normal / Abnormal
For Males:	Testicular Exam	Date: ________________	Normal / Abnormal
	Prostate Exam	Date: ________________	Normal / Abnormal
	Lipid Panel (Cholesterol)	Date: ________________	Normal / Abnormal

Surgical History

Procedure	Yes	Year	Comments
Abdominal Surgery			
Angioplasty (with or without stent)			
Appendectomy (Appendix Removal)			
Back Surgery			
Biopsy (Location)			
Breast Surgery/Biopsy			Circle: Right / Left / Both
Carpal Tunnel			Circle: Right / Left / Both
Colonoscopy			
Colostomy			
Coronary Bypass			
Coronary Stent			
EGD (Stomach Endoscopy)			
Cataract			
Gallbladder Removal			Laparoscopic? Yes / No
Gastric Bypass			
Heart Surgery (Other than Coronary Bypass)			
Hernia Repair			
Hip Surgery			Circle: Right / Left / Both
Hysterectomy (Total, including ovaries)			Circle: Laparoscopic / Vaginal / Abdominal
Hysterectomy (Partial, ovaries left)			Circle: Laparoscopic / Vaginal / Abdominal
Knee Surgery			Circle: Right / Left / Both
LASIX			
LEEP (Cervix Surgery)			
Neck Surgery			
Ovary Removal			Circle: Right / Left / Both
Pacemaker			
Sigmoidoscopy			
Sinus Surgery			
Small Bowel Resection			
Thyroidectomy			
Tubal Ligation			
Vasectomy			
Other:			
Other:			
Other:			

Family History

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative:	Comments
No Significant History Known										
ADD/ADHD										
Alcoholism/Drug Abuse										
Allergies										
Alzheimer’s										
Anxiety										
Asthma										
Arthritis										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Blood Disease (Please List)										
Cancer, Breast										
Cancer, Colon										
Cancer, Ovarian										
Cancer, Prostate										
Cancer, Other										
Colon Polyps										
COPD/Emphysema										
Coronary Artery Disease										
Depression										
Developmental Delay										
Diabetes										
Genetic Disorders (Explain)										
Glaucoma										
Heart Disease										
Hearing Disease										
Hepatitis B or C										
High Blood Pressure										
High Cholesterol										
Hip Fracture										
Kidney Disease										
Kidney Stones										
Learning Disabilities										
Migraine Headaches										
Mental Illness										
Obesity										
Osteoporosis										
Seizure Disorder										
Skin Conditions (Please List)										
Stroke										
Thyroid Disease										
Other:										
Other:										
Other:										

Health Issues

Tobacco Use:

Smoke Cigarettes? ☐ Never ☐ Former ☐ Yes

Current Smoker: Packs/day: ___________ Number of years: __________

Former smoker: Quit date: ___________ How many years did you smoke? __________

Approximately how many packs per day did you smoke? _____________

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use:

Do you drink alcohol? ☐ No ☐ Yes

Number of drinks/week: _____________

Type: ☐ Beer ☐ Wine ☐ Liquor

Caffeine Use:

Do you use caffeine? ☐ No ☐ Yes

Number of drinks/day: ______________

Type: ☐ Chocolate ☐ Coffee/Tea ☐ Energy Drinks ☐ Soda

Drug Use:

Do you use marijuana or recreational drugs? ☐ No ☐ Yes

Have you ever used needles to inject drugs? ☐ No ☐ Yes

Sexual Activity:

Sexually involved currently? ☐ No ☐ Yes

Sexual partner(s) is/are/have been: ☐ Male ☐ Female

History of STDs: ☐ No ☐ Yes, type: _______________________

Birth control method: ☐ None Needed ☐ Condom ☐ Pill ☐ Diaphragm ☐ Vasectomy

☐ Other: _________________________________

Social History

Occupation (or prior occupation): _________________________ Employer: _________________________

Highest level of education: ________________________________

Marital status: ☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed

Spouse/partner name: ___________________________________ Number of children: _______________

Women's Health History

Total number of pregnancies: _________ Number of births: ___________

Age at beginning of periods (menstruation): __________

Age at end of periods (menopause/hysterectomy): ___________ ☐ Not applicable

Date (month/date if known) of last menstrual period: _______________ How long do they last? ______ days