Adult Initial Health History Form

Name _____

First Middle Last

Today's Date_____ Date of Birth _____

Address_____

Telephone Number (home) (_____)_____

(cell) (_____)_____

(work) (_____)_____

GENERAL HEALTH

In general, what do you consider to be your **main health problem(s)**? (Check all that apply.)

☐ Heart problems ☐ Diabetes

☐ Stomach problems ☐ Depression/emotional problems

☐ Ear, nose, or throat problems ☐ Joint problems

☐ High blood pressure

☐ Other(s) – please explain_____

_____

3. How would you **describe your health**?

☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

4. Are you taking any **prescription medicines**?

☐ No, I do not take any prescription medicines. (If no, go to question #5.)

☐ Yes. Please list your medicines below OR ☐I brought my pill bottles or a list.

Name of medicine	Amount/ size of pill	How many pills or doses do you take at
Example: Furosemide	20 mg	_2_morning __2 noon ____dinner ____bed
		____morning ____noon ____dinner ____bed

		___morning ____noon ___dinner ___bed
		___morning ____noon ___dinner ___bed
		___morning ____noon ___dinner ___bed
		___morning ____noon ___dinner ___bed
		___morning ____noon ___dinner ___bed

(Please use the back of this form if you have more prescription medicines.)

5. What **over-the-counter medicines**, do you take regularly?

☐ Pain reliever (for example: Tylenol, Advil, Motrin, Aleve, aspirin)

☐ Vitamins

☐ Antacid (for example: Tums, Prilosec)

☐ Herbal medicine (please list) _____

☐ Other (please list) _____

☐ None - I do not take any over-the-counter medicines regularly.

6. Have you ever had any **allergic reaction (bad effects) to a medicine** or a shot?

☐ No, I am not allergic to any medicines.

☐ Yes. (Please write the name of the medicine and the effect you had.)

Medicine I am allergic to	What happens when I take that medicine
Example: Atenolol	I get a rash

7. Do you get an **allergic reaction (bad effect)** from any of the following? (Check all that apply)

☐ Latex (rubber gloves)

☐ Grass or pollen

☐ Eggs

☐ Shellfish

☐ Other (please describe) _____

☐ No - I have no allergies that I know of.

8. Have you ever been a **patient in a hospital** overnight?

☐No, I have never been a patient in a hospital. (If no, go to question #9)

☐Yes. (If yes, explain EACH reason and when.)

I was in the hospital because:	When
Example: Heart Attack	6 years ago

9. Have you ever had a **colonoscopy** (a test to look at your insides by sending a camera through your bottom)? ……..... ☐Yes ☐No

When _____

10. Have you ever received a **blood transfusion** (when you are given extra blood)? ……..... ☐Yes ☐No

When_____

FOR WOMEN ONLY

11. Have you ever been **pregnant**? ……☐ Yes ☐No

How many times?_____

How many children have you given birth to?_____

12. Have you had a **PAP smear**? ……☐ Yes ☐No

Date of last one _____

13. Have you ever had a **PAP smear that was not normal**? …… ☐ Yes ☐No

14. Have you had a **mammogram** (breast x-ray)?.....☐ Yes ☐No

Date of last one_____

Do you have low or high libido (sex drive)?

SHOTS

15. Covid shot?.....Year____ ☐Never ☐Don't know

16. When was your last **Pneumonia shot**?..... Year_____ ☐Never ☐Don't know

17. When was your last **Flu shot**?..... Year_____ ☐Never ☐Don't know

SOCIAL HISTORY

18. Circle the **highest grade** you finished in school?

1 2 3 4 5 6 7 8 Grade School | 9 10 11 12 High School | GED | 1 2 3 Vocational School | 1 2 3 4+ College

19. What **language** do you prefer to speak? ☐English ☐Spanish ☐Other _____

20. How well can you **read**?

☐ Very well ☐ Well ☐ Not well ☐ I can not read

21. **What do you do during the day**?

☐ Work full-time
☐ Work part-time
☐ Attend school
☐ Take care of children at home
☐ Go out most days (shop, visit, appointments)
☐ Stay home most days
☐ Other_____

22. Have you **ever smoked cigarettes, cigars, used snuff, or chewed tobacco**?

☐ No (if no, go to question #23.)
☐ Yes

a. When did you start?_____
b. How much per week? _____
c. Have you quit?..... ☐ No ☐ Yes, when_____

d. Do you want to quit?..... ☐ No ☐ Yes ☐ Already Quit

23. Do you drink **alcohol**?

☐ No (if no, go to question #24.)

☐ Yes

a. Have you ever felt you ought to cut down on your drinking? ☐Yes ☐No

b. Have people ever annoyed you by criticizing your drinking? ☐Yes ☐No

c. Have you ever felt bad or guilty about your drinking? ……...☐Yes ☐No

d. Have you ever had a drink first thing in the morning? ……...☐Yes ☐No

24. Are you ☐ Single ☐ Married ☐ Partnered ☐ Divorced or Separated ☐ Widowed?

25. Who lives in your house?_____

_____

26. Do you have **sex** with ☐ men ☐women ☐both ☐neither

Do you have problems getting an erection?

27. Do you have any **beliefs or practices from your religion, culture, or otherwise** that your doctor should know? For example:

☐ I do not accept blood/blood products because of personal or religious beliefs.

☐ I **do not use birth control** because of personal or religious beliefs.

☐ I **fast** (go without food) for periods of time for personal or religious reasons.

☐ I do not eat meat.

☐ I do not eat anything that comes from an animal.

☐ Other special diets or eating habits. (Please describe.) _____

☐ I use traditional medicines or treatments, such as acupuncture or herbs.

☐ Other beliefs_____

☐ **No**, I have no specific beliefs or practices that change the course of my health care.

☐ I do not need any help walking

30. In the past year, have you been **emotionally or physically abused** by your partner or someone important to you?.....☐ Yes ☐ No

31. In the past year have you been **hit, pushed, shoved, kicked or threatened** by a partner or someone important to you?..... ☐ Yes ☐ No

32. **EXERCISE**

Describe what kind of exercise you do. (Check all that apply.)	How many times per week do you exercise?	For how long do you exercise each day?
☐ walking ☐ biking ☐ swimming ☐ weight training ☐ yoga ☐ other ☐ I do not exercise	☐ once per week ☐ twice per week ☐ 3 times a week ☐ 4 times a week ☐ 5 times a week ☐ 6 times a week ☐ 7 times a week or more	☐ less than 15 minutes ☐ 15-30 minutes ☐ 30 – 45 minutes ☐ 45 minutes – 1 hour ☐ over 1 hour
Comments:		

FAMILY HISTORY

What medical problems do people in your family have?

Family Member	Medical Problems
Mother:	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ other:

Father:	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ other:
Sisters:	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ other:
Brothers:	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ other:

HISTORY OF MEDICAL CONDITIONS

Have you **ever** had any of the following conditions? (Check all that apply)

☐ Anemia (low iron blood) ☐ Asthma (wheezing) ☐ Diabetes (sugar)

☐ Heart Trouble ☐ Hemorrhoids (piles) ☐ Cancer

☐ Hepatitis (yellow jaundice) ☐ Tuberculosis (TB) ☐ Liver Trouble

☐ Pneumonia ☐ Rheumatic Fever ☐ Ulcers

☐ Stroke ☐ High Blood Pressure

☐ Skin problems ☐ Depression (feeling down or blue)

☐ Epilepsy (fits, seizures) ☐ Anxiety (nerves, panic attacks)

☐ VD, STD (syphilis, gonorrhea, chlamydia, HIV)

☐ Other_____

REVIEW OF SYMPTOMS

Sleeping	Do you **feel tired** a lot?	☐ Yes	☐ No
	Do you have **trouble falling or staying asleep**?	☐ Yes	☐ No
	Do you have **other problems with sleep**?	☐ Yes	☐ No
Eating	Have you **lost your appetite** recently?	☐ Yes	☐ No
	Have you **lost weight** in the last year without trying?	☐ Yes	☐ No

	Do you **eat too much** or **have you gained weight** recently?	☐ Yes	☐ No
	Do you have **other problems with eating**?	☐ Yes	☐ No
Throat	Do you have **sore throats** a lot?	☐ Yes	☐ No
	Do you have **other problems with your throat**?	☐ Yes	☐ No
Ears	Do you have **trouble hearing**?	☐ Yes	☐ No
	Do you wear a **hearing aid**?	☐ Yes	☐ No
	Do you have constant **ringing or noises** in your ears?	☐ Yes	☐ No
	Do you have **other problems with your ears?**	☐ Yes	☐ No
Back	Do you have **back pain**?	☐ Yes	☐ No
	Do you have any **other problems with your back**?	☐ Yes	☐ No
Eyes	Do you have **trouble with your vision** or seeing?	☐ Yes	☐ No
	Do you wear **glasses or contacts**?	☐ Yes	☐ No
	Do you have **other problems with your eyes**?	☐ Yes	☐ No
Nose and Sinuses	Do you have a **runny or stopped up nose** a lot?	☐ Yes	☐ No
	Do you have **other problems with your nose or sinuses?**	☐ Yes	☐ No
Teeth and Mouth	Do you have **sore or bleeding gums**?	☐ Yes	☐ No
	Do you wear **plates or false teeth**?	☐ Yes	☐ No
	Do you have **other problems with your teeth and mouth?**	☐ Yes	☐ No

REVIEW OF SYMPTOMS CONTINUED			
Heart or Breathing	Do you ever have **pain/tightness in your chest** when working or exercising?	☐ Yes	☐ No
	Do you **wake up at night with trouble breathing**?	☐ Yes	☐ No
	Do you have a **racing or skipping heartbeat** at times?	☐ Yes	☐ No
	Do you have **other heart or breathing problems**?	☐ Yes	☐ No
Bowel Movements	Do you have **bowel movements that are black, like tar, or bloody?**	☐ Yes	☐ No
	Do you have **any other problems with your bowel movements?**	☐ Yes	☐ No
Peeing and Kidney Stones	Do you have **trouble passing your urine**	☐ Yes	☐ No
	Does it **burn when you pass urine**	☐ Yes	☐ No
	Do you have to urinate **more than 2 times a night**?	☐ Yes	☐ No
	Do you **leak urine?**	☐ Yes	☐ No
	Have you ever passed **kidney stones**?	☐ Yes	☐ No
	Do you have any **other problems with your urination**	☐ Yes	☐ No
Joints	Do you have **swollen or painful joints**?	☐ Yes	☐ No
	Do you have any **other problems with your joints**?	☐ Yes	☐ No

REVIEW OF SYMPTOMS CONTINUED			
Head, Balance, Fever and Weakness	Do you have **frequent or severe headaches**?	☐ Yes	☐ No
	Have you ever **fainted (passed out)**?	☐ Yes	☐ No
	Have you **lost your balance and fallen** recently?	☐ Yes	☐ No
	Do you have **weakness** in any part of your body?	☐ Yes	☐ No
	Have you had a **fever** within the past month?	☐ Yes	☐ No
	Do you have any **other problems with your head or balance?**	☐ Yes	☐ No
Emotional Health	Do you get **upset easily**?	☐ Yes	☐ No
	Do **frightening thoughts** keep coming into your mind?	☐ Yes	☐ No
	Have you ever been **hospitalized for nerves, thoughts or moods**?	☐ Yes	☐ No
	During the past 2 weeks, have you often been bothered by having **little interest or pleasure in doing things**?	☐ Yes	☐ No
	During the past 2 weeks, have you often been bothered by feeling **down, depressed, or hopeless**?	☐ Yes	☐ No
	Do you have any **other problems with your emotional health?**	☐ Yes	☐ No
Men Only	Have you ever had **prostate trouble**?	☐ Yes	☐ No
	Do you have any **other male problems**?	☐ Yes	☐ No
Women Only	Do you have **pain or lumps in your breast**?	☐ Yes	☐ No
	Do you have unusual **vaginal discharge or itching**?	☐ Yes	☐ No
	Do you or have you taken **hormones (such as birth control pills or for menopause)**?	☐ Yes	☐ No
	Do you have any **other female problems**?	☐ Yes	☐ No