Adult Initial Health History Form

Name ____

First   Middle   Last

Date of Birth ________________

Prior PCP Name:___________________Phone and Fax number_______________

1. **Why did you make this appointment**? (Check all that apply.)

☐ Regular checkup

☐ First appointment to start care with a new doctor

☐ Switching doctors (from whom: ____)

☐ Have a specific health problem (if so, explain ____)

2. 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. 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.)

4. 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.

HISTORY OF MEDICAL CONDITIONS

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

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

☐ Heart Trouble ☐ Hemorrhoids ☐ Cancer (type)__________

☐ 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____

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

PAST SURGICAL HISTORY

9.Have you **ever** had surgery? (Check all that apply).

☐ Tonsils and/or Adenoids removed ☐ Gallbladder removed

☐ Hernia Repair ☐Hysterectomy ☐Partial hysterectomy

☐ Heart Valve Repair ☐Heart Stents Place

☐ Heart Bypass ☐Abdominal Surgery

☐ Orthopedic Surgery ☐ Ear tubes/tympanostomy tubes

☐ Sinus surgery ☐Brain surgery

☐ Breast Surgery ☐ Mastectomy

☐ Prostatectomy ☐Cataract Surgery

☐Other____

FAMILY HISTORY

10. 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: ___________________________________
Grandparents:	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ other: ___________________________________

SOCIAL HISTORY

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

☐ Work full-time

☐ Work part-time

☐ Attend school

☐ Other____________________________________

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

☐ No

☐ Yes

13. Do you drink **alcohol**?

☐ No

☐ Yes

SHOTS/SCREENINGS

14.When was your last **Tetanus shot**?.............Year_____ ☐Never ☐Don't know

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

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

17.When was your last Mammogram?............... Year_____ ☐Never ☐Don't know

18.When was your last Colonoscopy?................Year_____ ☐Never ☐Don't know