Name ______________________________________ Date of Birth __________________

Personal Health History Form- Adult

Current Medication *(*Including over-the-counter and vitamins/supplements)*:*

Medication	Dose	Times daily		Medication	Dose	Times daily

Allergies *(Medications, Food, Environmental):*

Allergy: ____ Type of reaction:):________________________________
Allergy: ____ Type of reaction:):________________________________
Allergy: ____ Type of reaction:):________________________________
Allergy: ____ Type of reaction:):________________________________
□ No Known Medication Allergies □No Known Other Allergies

Previous Medical History*:* Please describe any condition that you have yourself:

- Eye Disease/Cataracts____
- Lung Disease____
- Cancer (Type)____
- Heart Disease____
- Mood Disorder (Anxiety/Depression)____
- Diabetes____ Last Eye Exam______________
- Digestive/Stomach/GERD____
- Blood Clots/Pulmonary Embolus____
- High Blood Pressure____
- High Cholesterol____
- Kidney Disease____
- Sleep Apnea____
- Thyroid Disease____
- Other:____

____

Previous Surgeries: (please list date) □ No Previous Surgeries

____
____

Recent Hospitalization: (please list date) □ No Previous Hospitalizations

____
____

Please let us know if there is anything you would like us to know about you:

____
____
____

Who was your previous Primary Care Provider/Health Clinic? ___________________________________
Which pharmacy do you use?____

Preventative Medicine*: Please list dates for most recent exam/test:*

Complete Physical Exam:________________________
Pap Smear/Pelvic Exam:_________________________
Prostate Exam/PSA:____________________________
Mammogram:_________________________________
Colonoscopy:________________________________
Dexa Scan:_________________________________

Immunizations	
Shingles Vaccine	
Tetanus/Tdap	
Pneumovax (pneumonia)	
Menactra (Meningococcal)	
Gardisil (Cervical Cancer)	

Name ______________________________________ Date of Birth __________________

Family History:

Family Member		Medical History (Diabetes, Heart disease, Stroke, Cancer
Father	□Living YOB:_______ □Deceased (age:___)	
Mother	□Living YOB:_______ □Deceased (age:___)	
Children: Son(s) #_____ Daughter(s)#_____	□Living □Deceased (age:___)	
Brother(s) #_______ Sister(s) #________	□Living □Deceased (age:___)	

Have any of your family members including grandparents or Aunts/Uncles ever been diagnosed with any of the following? Elaborate on positive responses □Breast Cancer? ____________________ □Colon Cancer?_____________________
□Prostate Cancer____________________ □Early Heart Disease?________________

Marital Status: □ Single □Married □ Separated/Divorced □ Widowed/widower

Occupation: ____

Alcohol Use: **(**Type and Amount) ____

Tobacco History: □ No Tobacco History □Former Tobacco user: Type: __________________________ Quit Date: __________

□Current Tobacco user: Type: _____________ Start Date: ________________ Amount: _________________________

Illicit Drug use □No illicit Drug use Type and Amount: ____

Review of Systems

Are you currently experiencing any of the below – Circle any positive response

		General			**Gastrointestinal**
Yes	No	Fatigue: Duration__________	Yes	No	Diarrhea
Yes	No	Weight Gain/Loss	Yes	No	Constipation
Yes	No	Loss of Appetite	Yes	No	Abdominal Pain/Nausea
Yes	No	Fever	Yes	No	Rectal Bleeding
		Cardiovascular	Yes	No	Heartburn/Indigestion
Yes	No	Chest Pain			**Endocrine**
Yes	No	Shortness of Breath	Yes	No	Increased Thirst
Yes	No	Swelling of legs	Yes	No	Increased Urination
Yes	No	Palpitations/Fluttering	Yes	No	Heat/cold intolerance
		Dermatologic			**EENT**
Yes	No	Skin Rash/Itching	Yes	No	Vision Changes
Yes	No	New or changing Moles	Yes	No	Hearing Changes
Yes	No	Skin ulcer/Burn/Abscess	Yes	No	Seasonal Allergies
Yes	No	Easy Bruising/Bleeding	Yes	No	Cough
			Yes	No	Congestion
		Musculoskeletal/Neuro	Yes	No	Sore throat
Yes	No	Numbness/Tingling	Yes	No	Nose Bleeds
Yes	No	Injury/Fractures			
Yes	No	Joint Pain/Swelling			**Urinary**
Yes	No	Back Pain	Yes	No	Burning/Itching
Yes	No	Memory Loss/Confusion	Yes	No	Blood in Urine
Yes	No	Muscle Weakness	Yes	No	Frequent UTIs
			Yes	No	Frequent night time urination
		Psychological			
Yes	No	Anxiety/Panic Attacks			
Yes	No	Depression			
Yes	No	Inattentiveness			

Name ____ Date of Birth ___________________