Name______________________________________ DOB_____/______/_________

Personal Health History Form- Adult

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

Medication	Dose	Times daily		Medication	Dose	Times daily

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	Date
Shingles Vaccine	
Tetanus/Tdap	
Pneumovax (pneumonia)	
Menactra (Meningococcal)	
Gardasil (Cervical Cancer)	

Family History:

Family Member		Medical History (Diabetes, Heart disease, Stroke, Cancer etc.)
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

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