Adult Health History

Name:________________________________***Date of Birth***:_________***Age***:_________***Today's Date***:_______

Your answers on this form will help me better understand your medical concerns and history.

Chief Concerns (please rank by priority):

1._________________________________

2._________________________________

3._________________________________

REVIEW OF SYMPTOMS: *Please check off any symptoms you currently have.*

General
_____*Fevers/chills*
_____*Unexpected weight change*
_____*Fatigue/weakness*

Respiratory
_____*Cough/wheeze*
_____*Shortness of breath*

Skin
_____*Rash*
_____*Hair Loss*

Cardiovascular
_____*Chest pain*
_____*Palpitations*
_____*Leg swelling*

Eyes/Ears/Nose/Throat
_____*Change in vision*
_____*Change in hearing*
_____*Allergies/congestion*
_____*Difficulty swallowing*
_____*Sore throat*

Gastrointestinal
_____*Heartburn / reflux*
_____*Abdominal pain*
_____*Nausea/vomiting*
_____*Diarrhea/Constipation*

Neurological
_____*Headaches*
_____*Memory loss*
_____*Ringing in the ears*

Genitourinary
_____*Difficulty urinating*
_____*Frequency/urgency*
_____*Leaking urine*

Psychiatric
_____*Anxiety/Depression*
_____*Sleep problems*

Blood/Lymphatic
_____*Easy bruising*
_____*Unexplained lumps*

Musculoskeletal
_____*Muscle pain*
_____*Joint pain*

Other:___________________
____
____

MEDICATIONS/SUPPLEMENTS:

Name	***Dose***	***Name***	***Dose***
1.		**4.**	
2.		**5.**	
3.		**6.**	

MEDICATION ALLERGIES:

___Yes, please list:____

___No known drug allergies

SURGERY/TRAUMA HISTORY: *Please list any and all (major surgeries, falls, car accidents, emotional traumas, etc.), with dates, if possible:*

1.____________________________________ 4.____

2.____________________________________ 5.____

3.____________________________________ 6.____

Name:____***Date of Birth***:___________

PERSONAL & FAMILY HISTORY:

Medical Condition	**Self**	**Relative**	**Medical Condition**	**Self**	**Relative**
Alcoholism			*Heart Attack*		
Allergies			*High Blood Pressure*		
Anemia			*High Cholesterol*		
Arthritis			*Kidney Disease*		
Asthma			*Lupus*		
Birth Defects			*Migraines*		
Bleeding Disorder			*Osteoporosis*		
Cancer			*Rheumatoid Arthritis*		
Depression			*Stroke*		
Diabetes			*Thyroid Disease*		
Epilepsy			*Other:*		

SOCIAL HISTORY: *Please enter the appropriate answer.*

	Type	**# Per Day**	**# Years**	**Using Currently?**
Tobacco				*Yes No*
Alcohol				*Yes No*
Drugs				*Yes No*
Caffeine				*Yes No*

*Do you exercise regularly? Yes No If Yes, what kind?*____

*How much sleep do you get per night on average?*____

Are you happy with the amount of sleep you get?

Do you have a significant other?: Single Partner/Married Divorced Widowed Other

*Occupation (current or past if retired):*____

*Spiritual affiliation?:*____

*What are your major life stressors?*____

Do You Have a Primary Physician? *Yes No*

*If yes, please provide his/her name and contact info:*_______________________________________

Signature (Parent/Guardian if under 18yo): Date:

The above history has been reviewed with the patient: _____________________________________