

GRANDVIEW FAMILY MEDICINE

ADULT HEALTH HISTORY FORM

This questionnaire will become a confidential part of your medical record. **If you do not want to answer a question, leave it blank and discuss it privately with the doctor at your visit.**

Today's date: ____/____/____

Name: _____ Birthdate: ____/____/____
Last First Middle

Patient signature: _____ Age: _____

WHAT ARE THE MAIN REASONS FOR THIS VISIT?

PHYSICIAN'S COMMENTS

- 1. _____
- 2. _____
- 3. _____

MEDICAL HISTORY

Check major, **significant illnesses** which apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Mental Illness _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Heartburn/GERD | <input type="checkbox"/> PCOS |
| <input type="checkbox"/> Cancer(s) _____ | <input type="checkbox"/> Heart Problems _____ | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Tuberculosis/TB |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes (Type _____) | <input type="checkbox"/> Lupus | <input type="checkbox"/> Other: _____ |

SURGICAL/HOSPITAL

List the year of any Operations/Procedures you have had (if year unknown just J):

	Year		Year
Appendix surgery	_____	Hip surgery	_____
Back Surgery	_____	Hysterectomy	_____
Breast growth removal	_____	Knee Surgery	_____
Carpal tunnel	_____	Nasal/Sinus Surgery	_____
C-Section Delivery	_____	Plastic Surgery _____	_____
Colonoscopy	_____	Polyp Removed from Intestine	_____
D & C	_____	Prostate Surgery	_____
Eye Surgery	_____	Shoulder Surgery	_____
Foot/Ankle Surgery	_____	Thyroid surgery	_____
Gall Bladder Removal	_____	Tonsils removed	_____
Gastroscopy	_____	Tubal Ligation	_____
Heart Surgery	_____	Vasectomy	_____
Hernia	_____	Other _____	_____

List any **Broken Bones/Serious Accidents:**

_____ Year(s): _____

List any other **Hospitalizations:**

_____ Year(s): _____

MEDICATIONS

List all medications you are currently taking (including inhalers) and all over the counter drugs, vitamins or herbs.
Please list prescribed medications first:

Name of Medicine/Dose/Frequency:

- 1. _____ 6. _____
- 2. _____ 7. _____
- 3. _____ 8. _____
- 4. _____ 9. _____
- 5. _____ 10. _____

ALLERGIES

Medications:

- _____
- _____
- _____

Reactions:

- _____
- _____
- _____

Animals: _____

Reactions: _____

- Latex Tape Iodine Pollens Perfume Peanuts Gluten Milk Egg
- Other: _____

FAMILY HISTORY

Are you adopted? Yes No

List the cause of death for those who have died prior to age 50 (Do not include accidental deaths)

- Father _____ Mother's Father _____ Father's Father _____
- Mother _____ Mother's Mother _____ Father's Mother _____

Fill in any blood relatives that have any of the following illnesses: brother (b), sister (s), mother (m), father (f) or maternal grandparents (mother's side) m(gf), m(gm), or paternal grandparents (father's side) f(gf), f(gm).

- Alcoholism _____
- Alzheimer's/Dementia _____
- Anxiety _____
- Cancer (Breast) _____
- Cancer (Prostate) _____
- Cancer (Lung) _____
- Cancer _____
- Depression _____
- Diabetes (type _____) _____
- Emotional/Mental Illness _____
- High Blood Pressure _____
- Heart Attack prior to age 55 _____
- Heart Disease _____
- High Cholesterol _____
- Osteoporosis _____
- Stroke _____
- Substance Abuse _____
- Thyroid Disease _____

SOCIAL HISTORY

- 1. Occupation: _____ 2. Your sex: Female Male
- 3. Marital Status: Married Single Widowed Divorced
- 4. Race: Caucasian Hispanic Indian African American Asian Polynesian/Island Other: _____
- 5. Religious Preference: LDS Catholic Baptist Jewish Protestant N/A Other: _____
- 6. Please list number of children: Number of Sons _____ Number of Daughters _____
If you have minor children, do they live in your household? Yes No

7. Have you had extensive travel outside the United States (other than vacation) Yes No
8. What is your **smoking** status? Non-Smoker Past Current
 a. Year quit: _____ b. Number of years smoked: _____
 c. Indicate average number of packs used/day: _____
 d. Indicate type: Cigar Pipe Cigarette
 e. Would you like help to quit? Yes No
9. On average how many **alcoholic drinks** (1 drink = 12 oz. beer, 10 oz. wine cooler, 5 oz. wine, 1.5 oz. liquor) do you consume during one day? Non-drinker 1-2 3 or more
10. Do you follow a **special diet**? Yes No
 Diabetic Gluten Free Low Fat
 Low Calorie Vegetarian Other: _____
11. How many days per week do you **exercise** for at least 30 minutes? 0 1-2 3-5 6-7
 Walking Running Weight lifting
 Biking/exercise machine Swimming Aerobics
 Organized sports Other: _____
12. Do you need help from your doctor for an issue related to illegal **drugs**? Yes No
13. Do you need help from your doctor for a problem related to physical, verbal, or mental abuse? Yes No
14. Are you at risk for AIDS/(HIV)? Yes No
 (Homosexual, Bisexual, Multiple sex partners, needle drug use other than insulin)

LIFE STYLE AND HEALTH RISK

Women Only:

15. Have you had a Pap Smear within the last 3 years? Year _____ Yes No
 a. Have you had an abnormal Pap Smear? Yes No
16. Do you do monthly self breast exams? Yes No
17. Have you had a professional breast exam within the last three years? Year _____ Yes No
18. If 40 or above, have you discussed mammography with your doctor? Yes No
19. If 50 or above, have you had a mammogram within the last 2 years? Year _____ Yes No

Men Only:

20. Have you had a prostate exam? Yes No

Men and Women Over Age 50 Only:

21. Have you had your stool checked for blood within the last year? Yes No
22. Have you had a sigmoidoscopy (intestine exam) within the last 3-5 years? Yes No

Men and Women Age 65 or Greater Only:

23. Have you had a flu shot within the last 5 years? Yes No
24. Have you had a pneumonia shot? Yes No

Men and Women of All Ages:

25. Have you had a **tetanus/diphtheria** shot recently? Yes No
26. Have you had two **Measles, Mumps, Rubella** shots or the diseases as a child? Yes No
27. Have you had the following shots: Hepatitis A (Transmitted by food) Yes No
 Hepatitis B (Transmitted by body secretions) Yes No
28. Have you had your cholesterol checked within the last 5 years? Yes No
 Result _____ Year _____
29. Do you wear your seat belt? Yes No
30. Do you have an Advance Directive or DNR form? (like a living will for medical concerns) Yes No

REVIEW OF SYSTEMS

Check any condition(s) which are **SIGNIFICANT PROBLEMS** to you:

General

- Recent 10 lb. weight change
- Fevers (Frequent)
- Frequent profound fatigue
- Frequent difficulty sleeping
- Past blood transfusion

Head and Neck

- Visual changes (Not glasses)
- Dizziness
- Double vision
- Sinus problems
- Frequent persistent nosebleeds
- Ear pain
- Trouble hearing
- Ringing in the ear
- Hoarseness
- Persistent sore throat
- Mouth sores
- Swollen glands (Frequent)

Respiratory/Lungs

- Persistent cough
- Shortness of breath
- Coughing up blood
- Wheezing
- Stop breathing during sleep

Heart/Vascular

- Chest pain/tightness
- Irregular rapid heart beat
- Smothering feeling at night
- Ankle swelling

Stomach/Bowel

- Major appetite change
- Nausea/Vomiting (Frequent)
- Frequent heart burn/acid in throat (GERD)
- Abdominal pain
- Diarrhea (Frequent)
- Constipation (Frequent)
- Black/bloody stools
- Vomiting blood
- Difficulty swallowing

Kidney/Bladder

- Kidney/bladder infection
- Problem with bladder control
- Difficulty starting urination
- Frequent urination
- Increased urgency
- Urination more than once nightly
- Burning or painful urination
- Blood in the urine
- Difficulty emptying bladder

Reproduction

- Blood in semen/sperm (men)
- Inability to have an erection (men)
- Inability to reach climax
- Infertility
- Painful intercourse
- Decreased sexual desire
- Sexually Transmitted Diseases

Women

- Breast pain/lumps (women)
- Pelvic pain (women)
- Vaginal discharge (women)
- Frequent sweats/hot flashes (women)
- Menstrual problems
- Date of last period: _____
- Menopause
- Pregnancy problems
- Baby weighing 9 lbs. or more
- Number of full term births (>36 wks) _____
- Number of premature births (<36 wks) _____
- Number of miscarriages/abortions _____
- Number of living children _____

Skeletal

- Joint pain (major)
- Back pain (major)
- Neck pain (major)
- Weakness in arms/legs
- Joint swelling/stiffness
- Deformities of the back/extremities
- Gout

Neuro

- Numbness or tingling
- Severe frequent headaches
- Abnormal coordination
- Trouble with speech
- Forgetfulness/confusion

Skin and Hair Problems

- Changes in hair/hair loss (major)
- Wounds that will not heal
- Persistent rash
- Change in moles
- Major skin problems

Psych/Social

- Feeling blue/discouraged
- High anxiety/stress
- Loss of friends
- Feeling life has no purpose
- Feeling others are talking about you
- Feeling fear
- Hearing voices
- Marital or relationship problems
- Early morning awakenings