Adult Health History Form
Date: _____/_____/_____

Name: _____________________________________ Date of birth: ____/____/____

Allergies to medications _____________________________________________________________
_________________________________________________________________________________

Medications & Dosage: __________________________ _______________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Supplements: ________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Medical History:

<table>
<thead>
<tr>
<th></th>
<th>Good health</th>
<th>Poor health</th>
<th>Decreased</th>
<th>Cause of death</th>
<th>Stroke</th>
<th>Orthopnea</th>
<th>Asthma/allergy</th>
<th>Acalculia</th>
<th>Depression</th>
<th>Diabetes</th>
<th>Kidney/Bladder trouble</th>
<th>Dementia</th>
<th>Cancer</th>
<th>Throat disorder</th>
<th>Arthritis</th>
<th>Anxiety</th>
<th>Anemia</th>
<th>Heart Trouble</th>
<th>Hypertension</th>
<th>High Cholesterol</th>
<th>Gout</th>
<th>Renal Trouble</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siblings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandparents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
General:
Energy during the day: High ☐ Medium ☐ Low ☐
Exercise tolerance: Good ☐ Okay ☐ Poor ☐

What do you do for exercise, and how often? ____________________________________________
________________________________________________________________________________________

Any weight changes within the last year? _____ If so, how much? ____________________________
Do you use a seat belt? ______
Do you use a cell phone while driving? _____

Nervous System:
__Depression __Startle easily __Flatness __Migraines
__Anxiety __Addictive behavior __Seizures __Irritability __Motivation __Concussion If so, when? _______

Do you use tobacco? _____ If so, how much and for how long? _____________________________
Recreational drug use? ____ If so, please list: _____________________________________________

Men:
How often do you get up to urinate at night? ____________
Erection problems___
Groin pain ___
Testicular pain ___
Do you perform self testicular exams? ___
Libido problems___
Sexually active: Yes ☐ No ☐
Prostatitis: Yes ☐ No ☐
Have you ever had an elevated PSA test: Yes ☐ No ☐ If so, what were the results? _____________
Women:
Do you have PMS symptoms? ____ Please describe if so: _________________________________
Recurrent yeast infections: Yes ☐ No ☐
Birth control method __________________ For how long? ________________________________
Do you perform self breast exams regularly? ____
Have you ever been pregnant? ____ How many times? ____
Miscarriages ____
Abortions ____
Living children ____
Have you ever had an abnormal pap smear? ____ When? _________________
Did you receive treatment for an abnormal pap smear? _______________________________
Have you ever had a pelvic infection? ____ When? _______
Any problems or pain with intercourse? ____ If so, please describe _______________________
Do you use any vaginal hormones? _________________________________

Cardiovascular:
   ____ Elevated blood pressure     ____ Heart murmur
   ____ Heart palpitations          ____ Elevated cholesterol
   ____ Diabetes                    ____ Chest pain
Patient Name:_____________________________

Genitourinary:
__ Urine leakage/incontinence   __ Urinary tract infections
__ Kidney stones                __ Herpes Infections
__ Kidney infections           __ History of STD’s If so, please list: ______________

Pulmonary:
__ Asthma
__ Shortness of breath
__ Cough
__ History of bronchitis/pneumonia

Muscles/Joints:
__ Arthritis                     __ Back Pain Where? ______________
__ Gout                          __ Broken Bones When? ______________
__ Headaches

Thyroid:
__ Temperature sensitive         __ Dry skin
__ Constipation                  __ Weight gain
__ Fatigue                       __ Hair loss

ENT:
__ Throat clearing               __ Sinus infections
__ Glaucoma                      __ Airborne allergies
__ Cataracts                     __ Hay Fever
__ Tonsillitis                   __ Tonsillectomy

Skin:
__ Acne                          __ Eczema         __ Skin cancer

Gut:
__ Gas                           __ Bloating        __ Anemia
__ Heartburn                     __ Belly pain      __ Hemorrhoids
__ Constipation                  __ Diarrhea        __ Ulcers
__ Blood in stool                __ Colitis         __ Parasitic infection
__ Crohn’s Disease               __ Belching       __ Diverticulitis

# of BM’s per day ____
Sleep:
Time to bed ______ Awaken at ______
How do you feel in the morning? ____________________________________________
Do you use sleep aids? If so, please list. _______________________________________

__ Startle awake __ Gasping for air __ Shortness of breath
__ Trouble going to sleep __ Trouble waking up __ Observed apneas
__ Snoring

Trauma:
__ Motor vehicle accident(s)
__ Other ____________________________

Hospitalizations  Year  Type  Complications
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Diet:
Are you avoiding any foods? If so, please list. ________________________________
__ Food intolerance
__ Food allergies
Do you drink alcohol? ___ How many drinks per week? _____
Do you drink caffeine? ___ How often? ______________

What do you do to relax? ______________________________________________________
Who is your biggest emotional support? _________________________________________
What is your biggest stressor? _________________________________________________
What is your stress level from 1-10 (10 being the highest)? ______
When was your most recent:

- [ ] Bone density scan
- [ ] Fecal occult test
- [ ] Flu shot
- [ ] Pap smear
- [ ] Vision exam
- [ ] Vitamin D Test
- [ ] Cardiac stress test
- [ ] Colonoscopy
- [ ] Tetanus shot
- [ ] Mammogram
- [ ] Pneumococcal shot
- [ ] Cholesterol check
- [ ] PSA

Foreign Travel:

<table>
<thead>
<tr>
<th>Where</th>
<th>When</th>
<th>Illnesses</th>
<th>Vaccines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>