COMPREHENSIVE ADULT HEALTH HISTORY

Your answers on this form will assist your primary care provider in understanding your health care needs and allow us to properly care for you. We apologize for the length of the form but, want to make sure we collect all information required to properly care for you. If you cannot remember specific dates, please provide your best guess. Thank you in advance for completing this health history.

Name: ____ **Date of Birth:** ___________________

Main reason for today's visit: ____

Please list other healthcare providers and their specialty you see regularly: _________________________________
____

Previous primary care provider: ____

Allergies or intolerance to medications: (Please provide medication name and type of reaction)

Medication Name	Type of Reaction

Please list all prescription medications, over the counter medications and supplements you are currently taking:

Medication Name	Dose/Strength	Instructions/ times per day

Immunization History: (Please provide year of most recent vaccination)

Tetanus ________ **Pertussis/Tetanus**_________ **Pneumovax** ________ **Flu** ________ **Shingles** __________

Health Maintenance: (Please provide year of most recent examination as appropriate)

Colonoscopy ____________ **Performed at** ______________________________ **Normal** ____ **Abnormal** ___
Pap Smear ____________ **Performed at** ______________________________ **Normal** ____ **Abnormal** ___
Mammogram ____________ **Performed at** ______________________________ **Normal** ____ **Abnormal** ___
Bone Density ____________ **Performed at** ______________________________ **Normal** ____ **Abnormal** ___
Comments: ____
____

Family History

	Mother	Father	Sister(s)	Brothers(s)
Alive				
Deceased				
Age currently or at death				

Medical and Family History: (Please mark all conditions, past or present, that apply for you and your family. Parents & Brothers/Sisters most important)

Disease/Condition	Self	Family Member	Comment
Hypertension/High Blood Pressure			
Hyperlipidemia/High Cholesterol			
Heart Attack			
Heart Failure			
Diabetes-Adult Onset			
Diabetes-Childhood Onset			
Cancer-*Please indicate location in Comments*			
Kidney Disease			
Stroke			
Osteoporosis			
Alcoholism/Drug Abuse			
Depression			
Anxiety			
COPD/Emphysema			
Asthma			
Other: Describe			

Past Surgical History: Please list type of surgery, date and where performed.

Type of Procedure	Date	Where Performed

Other Health Issues:

Do you or have you ever smoked? No___ Yes____ / Cigarettes ___ Pipe___ Cigars / Former Smoker Quit Date_____

Packs per day ______ Number of Years _______ History of Exposure to Second Hand Smoke? No___ Yes____

Other Tobacco Use? Never____ Yes____ Former Chew/Dip Quit Date_____ Number of Years Used _________

Alcohol Use: Never ___ Yes ___ Number of Drinks per Day _____ Number of Years ______ Quit Date___________

Do you use recreational drugs? No___ Yes____ Type/Frequency? ____

Do you exercise regularly? No___ Yes____ Type/Frequency? ____

Do you currently work outside the home? No___ Yes___ Occupation:_______________________________________

If you are not currently working are you: ___ retired / ___unemployed / ___disabled; If disabled please provide reason for disability ____

Are you sexually active? ___ Not Currently / ___ Never / ___Yes

If sexually active, Type of Contraceptive Used?____

Women's Health

Total number of pregnancies:_____ Number of Births:____ Number of Miscarriages: ____ Number of Abortions: ___

Age at end of periods (menopause/hysterectomy): ______ / Not Applicable____