Date _____

Adult Patient History

Chart # _____

MRN # _____

Name: _____ Age: _____ Date of Birth _____ Sex: M F

Marital Status: Single Married Widowed Divorced Occupation: _____

Spouse/Significant Other Name: _____ Education: Highest Level Completed _____

What is the reason for your visit today? _____ Who referred you? _____

Vaccines	Approximate Date
Tetanus	_____
Flu	_____
Hep B	_____
Pneumovax	_____
MMR	_____
Chicken pox	_____
TB skin Test Positive Negative	_____

Exams	Approximate Date
Last Dental exam	_____
Last Eye exam	_____
Last Chest X-ray	_____
Last Colonoscopy/Sigmoidoscopy	_____
Last Mammogram	_____
Last Pap Smear	_____
Last Physical Exam	_____
Last Prostate Exam/PSA	_____
Other _____	_____

FAMILY HEALTH HISTORY:

Check (✔) if you or any blood relative has or has had any of the following and enter their relationship to you: *(Use the following abbreviations)* ***Y - yourself M - mother F - father B - brother S - Sister GF - grandfather GM - grandmother C - child***

Condition	Relationship	Condition	Relationship
Heart disease	_____	Rheumatic fever	_____
Lung disease *(asthma, bronchitis, emphysema, TB, etc.)*	_____	Stomach/Intestinal disorders	_____
Cancer *(breast, prostate, melanoma, leukemia, etc.)*	_____	Gallbladder disorders	_____
Stroke	_____	Thyroid disorders *(goiter)*	_____
High Blood Pressure	_____	Gout	_____
Diabetes	_____	Skin disorders	_____
Liver disease *(hepatitis, cirrhosis, jaundice, etc.)*	_____	Depression or other Mental Illness	_____
Kidney disorders *(including kidney stones)*	_____	Sexually transmitted disease *(HIV, Herp., PID, etc.)*	_____
Arthritis	_____	Alcohol/Drug abuse	_____
Blood disorders *(anemia, bleeding disorders, etc.)*	_____	Risk factors for HIV	_____
High Cholesterol	_____	Migraines/Headaches	_____
Allergies *(food, seasonal)*	_____	Other _____	_____

Current Medications – Prescription and Over-The-Counter Meds.
(including vitamins, herbs, aspirin, antacids, injectables, hormones)

Birth Control ***(Oral, Injectable)***

Are you allergic to any medicine? ☐ **Yes** ☐ **No**
Please list all medications and reactions

Past hospitalizations/surgeries/serious injuries
(including blood transfusions)

Do You	Yes	No	Type	Amt./Day	Date Quit
Use tobacco products	☐	☐			
Consume alcohol	☐	☐			
Drink caffeine	☐	☐			
Use or used illegal drugs	☐	☐			
Exercise regularly	☐	☐			
Have diet restrictions	☐	☐			
Travel outside US	☐	☐			

See Reverse Side

Today's Date _____ Chart # _____

Name: _____ MRN # _____

INDICATE WHICH APPLY TO YOU

GENERAL	Yes	No
1. Frequent infections	☐	☐
2. Weight change	☐	☐
3. Appetite/thirst change	☐	☐
4. Excessive fatigue/nervousness	☐	☐
5. Difficulty sleeping	☐	☐
6. Enlarged/tender lymph nodes or glands	☐	☐
7. Other _____		

EYES	Yes	No
1. Do you wear glasses/contacts	☐	☐
2. Vision changes	☐	☐
3. Red/itchy, watery eyes	☐	☐
4. Eye pain	☐	☐
5. Glaucoma	☐	☐
6. Dry eyes	☐	☐
7. Other _____		

EARS	Yes	No
1. Infections	☐	☐
2. Hearing loss	☐	☐
3. Earaches	☐	☐
4. Ear drainage	☐	☐
5. Buzzing/ringing	☐	☐
6. Feel "stopped up"	☐	☐
7. Other _____		

NOSE AND THROAT	Yes	No
1. Nasal stuffiness/drainage	☐	☐
2. Frequent nosebleeds	☐	☐
3. Sore throat	☐	☐
4. Mouth sores/ulcers	☐	☐
5. Hoarseness	☐	☐
6. Changes in taste	☐	☐
7. Teeth/gum problems	☐	☐
8. Snoring	☐	☐
9. Sleep apnea *(stop breathing while sleeping)*	☐	☐
10. Other _____		

PULMONARY	Yes	No
1. Shortness of breath/difficulty breathing	☐	☐
2. Cough-dry/productive	☐	☐
3. Asthma/wheezing	☐	☐
4. Night sweats	☐	☐
5. Fever/chills	☐	☐
6. Other _____	☐	☐

CARDIOVASCULAR	Yes	No
1. Heart attack/failure/angina	☐	☐
2. Chest pain/tightness	☐	☐
3. Irregular heartbeat	☐	☐
4. High blood pressure	☐	☐
5. Swelling of feet/ankles	☐	☐
6. Leg cramps with walking	☐	☐
7. Mitral Valve/Murmur	☐	☐
8. Other _____		

GASTROINTESTINAL	Yes	No
1. Heartburn /indigestion	☐	☐
2. Difficulty swallowing	☐	☐
3. Stomach pains/ulcers	☐	☐
4. Nausea/vomiting	☐	☐
5. Vomiting blood	☐	☐
6. Loose stools/diarrhea	☐	☐
7. Constipation	☐	☐
8. Hemorrhoids	☐	☐
9. Rectal bleeding	☐	☐
10. Black/bloody stools	☐	☐
11. Changes in bowel habits	☐	☐
12. Frequent laxatives	☐	☐
13. Liver problems/jaundice/hepatitis	☐	☐
14. Gallstones	☐	☐
15. Other _____		

BREAST	Yes	No
1. Lumps	☐	☐
2. Pain	☐	☐
3. Discharge	☐	☐
4. Other _____		

MALES ONLY	Yes	No
1. Prostate problems	☐	☐
2. Sexual difficulties	☐	☐
3. Testicle pain/lumps/swelling	☐	☐
4. Impotent	☐	☐
5. Discharge	☐	☐
6. Do you do regular testicle exams	☐	☐
7. Date of last prostate exam / PSA _____		
8. Venereal disease	☐	☐
9. Genital concerns	☐	☐
10. Other _____		

FEMALES ONLY	Yes	No
1. Excessive menstrual flow	☐	☐
2. Excessive menstrual pain	☐	☐
3. Vaginal discharge/odor	☐	☐
4. Vaginal dryness	☐	☐
5. PMS symptoms	☐	☐
6. Menopause/symptoms	☐	☐
7. Trouble conceiving	☐	☐
8. Problems with pregnancies	☐	☐
9. Sexual difficulties	☐	☐
10. Venereal disease	☐	☐
11. Genital concerns	☐	☐
12. Self breast exams per year _____		
13. Do you use birth control Type _____	☐	☐
14. Date of last pap _____		
15. History of Abnormal Pap Treatment _____	☐	☐
16. Date of last mammogram _____		
17. Age at onset of periods _____		
18. Frequency of periods _____		

FEMALES ONLY *(continued)*

19. Last menstrual period _____
20. Pregnancies _____
21. Live births _____
22. Miscarriages/abortions _____
23. Other _____

MUSCULOSKELETAL	Yes	No
1. Joint pain/tenderness	☐	☐
2. Joint swelling/warmth	☐	☐
3. Joint stiffness	☐	☐
4. Joint deformity	☐	☐
5. Muscle pain	☐	☐
6. Back/neck pain	☐	☐
7. Weakness	☐	☐
8. Prone to falls	☐	☐
9. Other _____	☐	☐

SKIN	Yes	No
1. Rashes	☐	☐
2. Dry/itchy skin	☐	☐
3. Bruising	☐	☐
4. Sweats	☐	☐
5. Mole/lesion changes	☐	☐
6. Skin color changes	☐	☐
7. Skin growths	☐	☐
8. Hair/nail problems	☐	☐
9. Other _____		

NEUROLOGIC	Yes	No
1. Headaches/migraines	☐	☐
2. Dizziness/nausea	☐	☐
3. Fainting/blackouts	☐	☐
4. Numbness/tingling	☐	☐
5. Paralysis	☐	☐
6. Seizures/convulsions	☐	☐
7. Coordination problems	☐	☐
8. Memory loss	☐	☐
9. Other _____		

PSYCHIATRIC	Yes	No
1. Mental illness	☐	☐
2. Anxiety	☐	☐
3. Depression	☐	☐
4. Suicidal thoughts	☐	☐
5. Overly emotional/mood swings	☐	☐
6. Hallucinations	☐	☐
7. Phobias	☐	☐
8. Other _____		

URINARY	Yes	No
1. Pain/burning on urination	☐	☐
2. Urinary frequency	☐	☐
3. Difficulty starting urine	☐	☐
4. Incontinence *(wetting)*	☐	☐
5. Bloody urine	☐	☐
6. Other _____		

Provider Review: _____ Date: _____

Provider Review: _____ Date: _____

Provider Review: _____ Date: _____