**Adult Health History**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appointment Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City&Prov\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postal Code\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

 May I text you? Yes No

 Work (optional) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name (Relationship) Contact Number

Office Use

Ht: \_\_\_\_\_\_\_\_\_\_ Wt:\_\_\_\_\_\_\_\_\_\_

**GENERAL HEALTH**

1. In general, what do you consider to be your **main health problem(s)**? (Check all that apply)

€ Heart problems € Diabetes

€ Stomach problems € Depression/emotional problems

€ Ear, nose, or throat problems € Joint problems

€ High blood pressure € None

€ Other(s)- Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. For dental, do you: € Make regular scheduled visits € Only make visits when you have to
2. For optometry, do you: € Make regular scheduled visits € Only make visits when you have to
3. Are you taking any **prescription medicines**?

€ YES. Please list your medications below **OR** € YES, I brought my pill bottles/list.

€ NO, I do not take any prescription medicines. (If no, go to question #5.)

|  |  |  |
| --- | --- | --- |
| **Name of medicine** | **Amount/size of pill** | **How many pills/doses do you take at:** |
| **Example: Furosemide** | **20 mg** | \_**2**\_morning \_**2**\_noon \_\_\_dinner \_\_\_bed |
|  |  | \_\_\_morning \_\_\_noon \_\_\_dinner \_\_\_bed |
|  |  | \_\_\_morning \_\_\_noon \_\_\_dinner \_\_\_bed |
|  |  | \_\_\_morning \_\_\_noon \_\_\_dinner \_\_\_bed |
|  |  | \_\_\_morning \_\_\_noon \_\_\_dinner \_\_\_bed |
|  |  | \_\_\_morning \_\_\_noon \_\_\_dinner \_\_\_bed |
|  |  | \_\_\_morning \_\_\_noon \_\_\_dinner \_\_\_bed |

(Please use the back of this form if you have more prescription medicines)

1. What **over-the-counter medicines** do you take regularly?

€ Pain reliever (i.e. Tylenol, Advil, Motrin, Aleve, Aspirin)

€ Vitamins

€ Antacid (i.e. Tums, Prislosec)

€ Herbal medicine- Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

€ Other- Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

€ None- I do not take any over-the-counter medicines regularly.

1. Have you ever had any **allergic reaction (bad effects) to a medicine** or a shot?

€ YES. Please write the name of the medicine and the effect you had in chart below.

€ NO, I am not allergic to any medicines.

|  |  |
| --- | --- |
| **Medicine I am allergic to:** | **What happens when I take that medicine** |
| **Example: Atenolol** | **I get a rash** |
|  |  |
|  |  |
|  |  |
|  |  |

1. Have you had a **FIT test** (fecal scraping) done? € YES When:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ € NO
2. Have you ever had a **colonoscopy** (a test to look at your insides by sending a camera through your bottom)?

€ YES. When:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

€ NO

1. How much of the following do you consume each day?

 Coffee/Tea (cups) \_\_\_\_\_\_\_\_\_\_ Pop\_\_\_\_\_\_\_\_\_\_\_ Alcohol (drinks/wk)\_\_\_\_\_\_\_\_\_\_

 Dairy (servings)\_\_\_\_\_\_\_\_\_\_ Vitamin D\_\_\_\_\_\_\_\_ Multivitamin\_\_\_\_\_\_\_\_

**FOR WOMEN ONLY**

1. Have you ever been **pregnant**?

€ YES- How many times? \_\_\_\_\_ How many children have you given birth to? \_\_\_\_\_

€ NO

1. Have you had a **PAP smear**? € YES- Date of last one\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ € NO
2. Have you ever had a **PAP smear that was not normal**? € YES €NO
3. Have you had a **mammogram** (breast x-ray)? € YES- Date of last one:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ € NO

**SOCIAL HISTORY**

1. Have you ever **smoked cigarettes, cigars, used snuff, or chewed tobacco**?

 € NO (If no, go to question #15)

 € YES

1. When did you start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How much per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you quit? € NO (go to 'D')

 € YES-When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (go to question #15)

1. Do you want to quit? € NO €YES
2. Are you: € Single € Dating € Common-Law € Partnered € Engaged € Married

 € Divorced/Separated € Widowed

1. a) Do you use street drugs? € Yes € No b) Do you use marijuana/cannabis? € Yes € No
2. Are you a **vegetarian** (do not eat meat)? € Yes € No
3. **EXERCISE**

|  |  |  |
| --- | --- | --- |
| **Describe what kind of exercise you do. Check all that apply.** | **How many days per week do you exercise?** | **For how long do you exercise each day?**  |
| € Walking€ Biking€ Swimming€ Weight training€ Yoga€ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_€ I do not exercise | € Once per week€ Twice per week€ 3 times a week€ 4 times a week€ 5 times a week€ 6 times a week€ 7 times a week  | € Less than 15 minutes€ 15-30 minutes€ 30-45 minutes€ 45 minutes – 1 hour€ Over 1 hour |
| Comments:  |

**FAMILY HISTORY**

 What medical problems do people in your family have?

|  |  |
| --- | --- |
| **Family Member**  | **Medical Problems** |
| Mother | € Diabetes (sugar) € High Blood Pressure € Heart Problems€ Cancer € Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Father | € Diabetes (sugar) € High Blood Pressure € Heart Problems€ Cancer € Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sisters | € Diabetes (sugar) € High Blood Pressure € Heart Problems€ Cancer € Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Brothers | € Diabetes (sugar) € High Blood Pressure € Heart Problems€ Cancer € Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**HISTORY OF MEDICAL CONDITIONS**

Have you **ever** had any of the following conditions? (Check all that apply)

 € Anemia (low iron blood) € Asthma

 € Heart trouble € Hemorrhoids (piles)

 € Hepatitis (yellow jaundice) € Tuberculosis (TB)

 € Pneumonia € Rheumatic Fever

 € Stroke € High Blood Pressure

 € Skin Problems € Depression (feeling down or blue)

 € Epilepsy (fits, seizures) €Anxiety (nerves, panic attacks)

 € VD, STD (syphilis, gonorrhea, Chlamydia, HIV) € Diabetes (sugar)

 € Liver Trouble € Ulcers

€ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ € Cancer

€ Surgeries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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