Adult Health History

Doctor you are seeing today (Circle one): Yang, Schettler-Huberty, Furman, Desai, March

Do we see any of your family members? If so, who may we thank for your referral? _____

Today's Date: _____

Patient Name: _____

Date of birth: _____ Age: _____ Gender: _____

Height: _____ Weight: _____

What is the primary reason for your visit with the doctor today?

_____

	Yes	No
Latex Allergy	□	□
Drug Allergies	□	□

Please list **medications** and **reactions**:

_____

Medications

Please list any medications that you take on a regular basis. Include medication **name**, **dose**, and **frequency**:

_____

_____

Past Medical History

	Yes	No
Do you have any medical problems?	□	□

Please list:

_____

_____

	Yes	No
Have you ever had cancer?	□	□

If so, what type?

_____

Past Surgical History

	Yes	No
Have you ever had surgery?	□	□

Please list type and approximate date:

_____

Family History

Any family history of the following?	Yes	No	**If answered yes, please list family member(s) relation:**
Heart Disease	□	□	_____
Arthritis	□	□	_____
Cancer	□	□	_____
Diabetes	□	□	_____
Bleeding tendencies	□	□	_____
Other: _____			_____

SEE BACK PAGE →

Habits

	Yes	No
Do you drink alcohol?	□	□
If yes, how many drinks per week? _____		
Do you currently use illicit drugs?	□	□
If yes, what drugs? _____		
Have you ever used tobacco products?	□	□
If yes, for how many years? _____		
If yes, how many packs per day? _____		
Have you stopped?	□	□
If yes, what date or how long ago? _____		

Review of Systems

Do you CURRENTLY have any of the following symptoms?

	Yes	No
Constitutional Systems		
Fever	□	□
Chills	□	□
Fatigue	□	□
Unexpected Weight loss	□	□
Eyes		
Itchy Eyes	□	□
Visual disturbances	□	□
Light sensitivity	□	□
Respiratory		
Wheezing	□	□
Frequent cough	□	□
Shortness of breath	□	□
Apnea	□	□
Cardiovascular		
Chest pain	□	□
Chest tightness	□	□
Heart attack	□	□
Gastrointestinal		
Abdominal pain	□	□
Nausea/vomiting	□	□
Acid reflux/heartburn	□	□
Voice hoarseness	□	□
Trouble swallowing	□	□

	Yes	No
Neurological		
Dizziness	□	□
Headaches	□	□
Ringing in ears	□	□
Numbness/tingling	□	□
Hearing loss	□	□
Ear Pain	□	□
Endocrine		
Excessive thirst	□	□
Hot/cold Intolerance	□	□
Hematological/Lymphatic		
Easy bruising/Bleeds easily	□	□
Swollen lymph nodes	□	□
Nosebleeds	□	□
Allergy/Immunologic		
Runny nose	□	□
Post nasal drip	□	□
Congestion	□	□
Pets in the home	□	□
Immunocompromised	□	□

Preferred Pharmacy: _____

Location: _____

Please return the completed form to the front desk
Thank you!