

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
<u>Latex Allergy</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Drug Allergies</u>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>

Please list:

	Yes	No
Have you ever had cancer?	<input type="checkbox"/>	<input type="checkbox"/>

If so, what type?

Past Surgical History

	Yes	No
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>

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:
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Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
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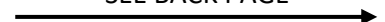
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Bleeding tendencies	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Other: _____			_____
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Habits

	Yes	No
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many drinks per week? _____		
Do you currently use illicit drugs?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what drugs? _____		
Have you ever used tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, for how many years? _____		
If yes, how many packs per day? _____		
Have you stopped?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what date or how long ago? _____		

Review of Systems

Do you CURRENTLY have any of the following symptoms?

	Yes	No		Yes	No
Constitutional Systems			Neurological		
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Ring in ears	<input type="checkbox"/>	<input type="checkbox"/>
Unexpected Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>
			Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Eyes			Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>
Itchy Eyes	<input type="checkbox"/>	<input type="checkbox"/>			
Visual disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine		
Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
			Hot/cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory					
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Hematological/Lymphatic		
Frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising/Bleeds easily	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Swollen lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular			Allergy/Immunologic		
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Runny nose	<input type="checkbox"/>	<input type="checkbox"/>
Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>
			Pets in the home	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal			Immunocompromised	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>			
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>			
Acid reflux/heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Preferred Pharmacy: _____		
Voice hoarseness	<input type="checkbox"/>	<input type="checkbox"/>			
Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Location: _____		

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