Rosewood Health Care

Adult Self History Form

Name: _____ What name would you like to be called? _____ DOB: _____

Age: _____ Sex: ___ Male ___ Female Race: _____ Religious preference:_____

Please check one ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

Who do you currently live with? Alone ___ Family ___ Friends ___Significant other____

Current job: _____ Previous job: _____ Highest level of education?_____

MEDICATIONS (Please include all prescriptions, over-the-counter, vitamins, and supplements)

Name & Dose of Medication	Reason for taking the medication

ALLERGIES TO ANY MEDICATIONS, X-RAY DYES OR OTHER SUBSTANCES? YES NO

(If yes, please list name of medication and type of reaction)_____

_____

_____

SURGERIES/HOSPITALIZATIONS – Please list date and details; circle either surgery or hospitalization

Date	Surg/Hosp	Reason/Details

SEVERE INJURIES

Please list dates and details of any injuries you have ever had

_____

_____

IMMUNIZATIONS

Date of last Tetanus vaccine? _____

Date of Hepatitis B series? _____

Date of last Pneumonia vaccine? _____

Date of TB screening? _____ + or –

Date of chicken pox disease or shot? _____

Date of last Flu vaccine? _____

Date of Gardasil series? _____

HEALTH MAINTENANCE

Date your last colonoscopy? _____

Date of your last mammogram? _____

Date of your last eye exam? _____

Date of your last pap smear? _____

Date of your last bone density test? _____

Date of last wellness exam? _____

Please circle one - Do you consider yourself: Underweight Normal Weight Overweight Obese

What kind of exercise do you do? _____ How often? _____

Do you wear seat belts? YES NO Do you use sunscreen? YES NO

Do you feel safe at home? YES NO Do you text while driving? YES NO

Do you drink coffee/soda/tea? YES NO If yes, how many cups/cans a day?_____

What type of birth control is used between you and your partner? _____

Which of the following conditions are currently being treated or have been treated for in the past?

___Allergies ___Asthma ___Arthritis ___Anxiety ___Anemia
___Abnormal EKG ___Alcoholism ___Acid reflux ___Blood clots ___Bleeding
___Blood Transfusion ___Back pain ___Breast lumps ___Cancer ___Chest pain
___Colitis ___Concussion ___Cold Sores ___Constipation ___Diabetes
___Depression ___Dizziness ___Diarrhea ___Drug overdose/abuse ___Eczema
___Emphysema/COPD ___Erectile dysfunction ___Epilepsy/Seizures ___Glaucoma ___Gallbladder
___Genital herpes ___Gout ___Headaches ___Hearing Problem ___Hernia
___Heart attack ___Heart murmur ___Heart disease ___Hepatitis ___Herniated disk
___High blood pressure ___Hemorrhoids ___Heart failure ___High cholesterol ___HIV/AIDS
___Hodgkin's ___Insomnia ___Irritable Bowel ___Kidney disease ___Kidney stones
___Liver disease ___Leukemia ___Lung problems ___Lupus ___Meningitis
___Migraines ___Muscle disease ___OCD ___Pancreatitis ___Panic attacks
___Pneumonia ___Psoriasis ___Polio ___Sickle cell disease ___STD _____
___Stroke ___Skin disease ___Sinus disease ___Suicide attempt ___Thyroid disease
___Tuberculosis/Positive TB test ___Ulcer disease ___Urinary infections ___Other _____

FAMILY HISTORY – Please put a checkmark in all applicable boxes

Were you adopted? YES or NO

Illness	Father	Mother	Sibling	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Anemia									
Asthma									
Bleeding/Clotting Disorders									
Cancer: Breast									
Cancer: Lung									
Cancer: Ovarian									
Cancer: Other									
Cancer: Prostate									
Cancer: Skin									
Colon/Bowel Problems									
Depression/Anxiety									
Diabetes									
Drug/Alcohol Addiction									
Glaucoma									
Heart Attack									
Heart Disease									
High Blood Pressure									
High Cholesterol									
HIV/AIDS									
Kidney Disease									
Liver Disease									
Seizures/Epilepsy									
Stroke									
Suicide									
Thyroid Disease									
OTHER:									

OB/GYN HISTORY

Age of first menses: _____ Date of last period: _____ Do you suffer from PMS? YES or NO

Have you ever had an abnormal pap? YES or NO - If yes, date and results _____

Pregnancies: Total Number ____ Full Term _____ Miscarriages ____ Abortions ____ Premature ____ Tubal _____

Complications_____

SOCIAL HISTORY

Are you sexually active? YES or NO If yes, are your sexual partners? MEN WOMEN BOTH

Have you ever been diagnosed with a sexually transmitted disease? YES or NO Diagnosis: _____

Do you smoke? YES NO How many per day? _____ Have you ever quit? YES NO

Do you use other tobacco products? _____ When? _____

Do you drink alcohol? YES NO How many per day? _____ How many per week? _____

Have you ever had a problem with alcohol in the past? YES NO Explain _____

Has anyone ever expressed concerns about your alcohol use? YES NO Explain _____

Do you currently use any recreational drugs? YES NO What types? _____

Have you ever had a drug problem in the past (prescription drug addiction/illegal drug use)? YES NO

If yes, explain _____