GRANDVIEW FAMILY MEDICINE

ADULT HEALTH HISTORY FORM

This questionnaire will become a confidential part of your medical record. **If you do not want to answer a question, leave it blank and discuss it privately with the doctor at your visit.**

Today's date: _____/ _____/ _____

Name: _____ Birthdate: ____/ ____/ ____
Last First Middle

Patient signature: _____ Age: _____

WHAT IS THE MAIN REASON FOR THIS VISIT? **PHYSICIAN'S COMMENTS**

1. _____

MEDICAL HISTORY

Check major, **significant illnesses** which apply to you:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Cancer(s)_____
- ☐ Celiac Disease
- ☐ Clotting Disorder
- ☐ COPD
- ☐ Depression
- ☐ Diabetes (Type _____)
- ☐ Eating Disorder
- ☐ Endometriosis
- ☐ Fibromyalgia
- ☐ Epilepsy/Seizures
- ☐ Heartburn/GERD
- ☐ Heart Problems_____
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Genetic Disorder
- ☐ Kidney Stones
- ☐ Lupus
- ☐ Mental Illness_____
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ PCOS
- ☐ Seasonal Allergies
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis/TB
- ☐ Ulcers
- ☐ Other:_____

SURGICAL/HOSPITAL

List the year of any Operations/Procedures you have had (if year unknown just √):

	Year		Year
Appendix surgery	_____	Hip surgery	_____
Back Surgery	_____	Hysterectomy	_____
Breast growth removal	_____	Knee Surgery	_____
Carpal tunnel	_____	Nasal/Sinus Surgery	_____
C-Section Delivery	_____	Plastic Surgery_____	_____
Colonoscopy	_____	Polyp Removed from Intestine	_____
D & C	_____	Prostate Surgery	_____
Eye Surgery	_____	Shoulder Surgery	_____
Foot/Ankle Surgery	_____	Thyroid surgery	_____
Gall Bladder Removal	_____	Tonsils removed	_____
Gastroscopy	_____	Tubal Ligation	_____
Heart Surgery	_____	Vasectomy	_____
Hernia	_____	Other_____	_____

List any **Broken Bones/Serious Accidents:**

_____ Year(s): _____

List any other **Hospitalizations:**

_____ Year(s): _____

MEDICATIONS

List all medications you are currently taking (including inhalers) and all over the counter drugs, vitamins or herbs.
Please list prescribed medications first:

Name of Medicine / Dose / Frequency:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

ALLERGIES

Medications: Reactions:

_____ _____
_____ _____
_____ _____
_____ _____

Animals: _____ Reactions:_____

☐ Latex ☐ Tape ☐ Iodine ☐ Pollens ☐ Perfume ☐ Peanuts ☐ Gluten ☐ Milk ☐ Egg

☐ Other: _____

FAMILY HISTORY

Are you adopted? ☐ Yes ☐ No

List the cause of death for those who have died prior to age 50 (Do not include accidental deaths)

Father _____ Mother's Father _____ Father's Father _____
Mother _____ Mother's Mother _____ Father's Mother _____

Fill in any blood relatives that have any of the following illnesses: brother (b), sister (s), mother (m), father (f) or maternal grandparents (mother's side) m(gf), m(gm), or paternal grandparents (father's side) f(gf), f(gm).

☐ Alcoholism _____
☐ Alzheimer's/Dementia _____
☐ Anxiety _____
☐ Cancer (Breast) _____
☐ Cancer (Prostate) _____
☐ Cancer (Lung) _____
☐ Cancer_____ _____
☐ Depression _____
☐ Diabetes (type_____) _____
☐ Emotional/Mental Illness _____
☐ Heart Attack prior to age 55 _____
☐ Heart Disease _____
☐ High Blood Pressure _____
☐ High Cholesterol _____
☐ Osteoporosis _____
☐ Stroke _____
☐ Substance Abuse _____
☐ Thyroid Disease _____

SOCIAL HISTORY

1. Occupation: _____ 2. Your gender: ☐ Female ☐ Male
3. Marital Status: ☐ Married ☐ Single ☐ Engaged ☐ Divorced ☐ Widowed
4. Race: ☐ Caucasian ☐ Hispanic ☐ Native American ☐ African American ☐ Asian ☐ Polynesian/Island ☐ Indian
5. Religious Preference: ☐ LDS ☐ Catholic ☐ Baptist ☐ Jewish ☐ Protestant ☐ N/A ☐ Other: _____
6. Number of children: Number of Sons _____ Number of Daughters _____ Miscarriages/Abortions _____

7. Have you had extensive travel outside the United States (other than vacation) ☐ Yes ☐ No

8. What is your **smoking** status? ☐ Never ☐ Former ☐ Current
   a. Year quit: _____ b. Number of years smoked: _____
   c. Indicate average number of packs used/day: _____
   d. Indicate type: ☐ Cigar ☐ Pipe ☐ Cigarette
   e. Would you like help to quit? ☐ Yes ☐ No

9. On average how many **alcoholic drinks** (1 drink = 12 oz. beer, 10 oz. wine cooler, 5 oz. wine, 1.5 oz. liquor) do you consume during one day? ☐ Never ☐ Social Drinker ☐ 1-2 ☐ 3 +

10. Do you follow a **special diet**? ☐ Yes ☐ No
    ☐ Diabetic ☐ Gluten Free ☐ Low Fat
    ☐ Low Calorie ☐ Vegetarian ☐ Other: _____

11. How many days per week do you **exercise** for at least 30 minutes? ☐0 ☐1-2 ☐3-5 ☐6-7
    ☐ Walking ☐ Running ☐ Weight lifting
    ☐ Biking/exercise machine ☐ Swimming ☐ Aerobics
    ☐ Organized sports ☐ Other: _____

12. Do you need help from your doctor for an issue related to illegal **drugs**? ☐ Yes ☐ No

13. Do you need help from your doctor for a problem related to physical, verbal, or mental abuse? ☐ Yes ☐ No

14. Are you at risk for AIDS/(HIV)? ☐ Yes ☐ No
    (Homosexual, Bisexual, Multiple sex partners, needle drug use other than insulin)

LIFE STYLE AND HEALTH RISK

Women Only:

15. Have you had a Pap Smear within the last 3 years? Year_____ ☐ Yes ☐ No
    a. Have you had an abnormal Pap Smear? ☐ Yes ☐ No
16. Do you do monthly self breast exams? ☐ Yes ☐ No
17. Have you had a professional breast exam within the last three years? Year _____ ☐ Yes ☐ No
18. If 40 or above, have you discussed mammography with your doctor? ☐ Yes ☐ No
19. If 50 or above, have you had a mammogram within the last 2 years? Year _____ ☐ Yes ☐ No

Men Only:

20. Have you had a prostate exam? ☐ Yes ☐ No

Men and Women Over Age 50 Only:

21. Have you had your stool checked for blood within the last year? ☐ Yes ☐ No
22. Have you had a sigmoidoscopy (intestine exam) within the last 3-5 years? ☐ Yes ☐ No

Men and Women Age 65 or Greater Only:

23. Have you had a flu shot within the last 5 years? ☐ Yes ☐ No
24. Have you had a pneumonia shot? ☐ Yes ☐ No

Men and Women of All Ages:

25. Have you had a **tetanus/diphtheria** shot recently? ☐ Yes ☐ No
26. Have you had two **Measles, Mumps, Rubella** shots or the diseases as a child? ☐ Yes ☐ No
27. Have you had the following shots: Hepatitis A (Transmitted by food) ☐ Yes ☐ No
    Hepatitis B (Transmitted by body secretions) ☐ Yes ☐ No
28. Have you had your cholesterol checked within the last 5 years? ☐ Yes ☐ No
    Result _____ Year _____
29. Do you wear your seat belt? ☐ Yes ☐ No
30. Do you have an Advance Directive or DNR form? (like a living will for medical concerns) ☐ Yes ☐ No

REVIEW OF SYSTEMS

Check any condition(s) which are **SIGNIFICANT PROBLEMS** to you:

General
- ☐ Recent 10 lb. weight change
- ☐ Fevers (Frequent)
- ☐ Frequent profound fatigue
- ☐ Frequent difficulty sleeping
- ☐ Past blood transfusion

Head and Neck
- ☐ Visual changes (Not glasses)
- ☐ Dizziness
- ☐ Double vision
- ☐ Sinus problems
- ☐ Frequent persistent nosebleeds
- ☐ Ear pain
- ☐ Trouble hearing
- ☐ Ringing in the ear
- ☐ Hoarseness
- ☐ Persistent sore throat
- ☐ Mouth sores
- ☐ Swollen glands (Frequent)

Respiratory/Lungs
- ☐ Persistent cough
- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Stop breathing during sleep

Heart/Vascular
- ☐ Chest pain/tightness
- ☐ Irregular rapid heart beat
- ☐ Smothering feeling at night
- ☐ Ankle swelling

Stomach/Bowel
- ☐ Major appetite change
- ☐ Nausea/Vomiting (Frequent)
- ☐ Frequent heart burn/acid in throat (GERD)
- ☐ Abdominal pain
- ☐ Diarrhea (Frequent)
- ☐ Constipation (Frequent)
- ☐ Black/bloody stools
- ☐ Vomiting blood
- ☐ Difficulty swallowing

Kidney/Bladder
- ☐ Kidney/bladder infection
- ☐ Problem with bladder control
- ☐ Difficulty starting urination
- ☐ Frequent urination
- ☐ Increased urgency
- ☐ Urination more than once nightly
- ☐ Burning or painful urination
- ☐ Blood in the urine
- ☐ Difficulty emptying bladder

Reproduction
- ☐ Blood in semen/sperm (men)
- ☐ Inability to have an erection (men)
- ☐ Inability to reach climax
- ☐ Infertility
- ☐ Painful intercourse
- ☐ Decreased sexual desire
- ☐ Sexually Transmitted Diseases

Women
- ☐ Breast pain/lumps (women)
- ☐ Pelvic pain (women)
- ☐ Vaginal discharge (women)
- ☐ Frequent sweats/hot flashes (women)
- ☐ Menstrual problems
  Date of last period: _____
- ☐ Menopause
- ☐ Pregnancy problems
- ☐ Baby weighing 9 lbs. or more

Number of full term births (>36 wks) _____
Number of premature births (<36 wks) _____
Number of miscarriages/abortions _____
Number of living children _____

Skeletal
- ☐ Joint pain (major)
- ☐ Back pain (major)
- ☐ Neck pain (major)
- ☐ Weakness in arms/legs
- ☐ Joint swelling/stiffness
- ☐ Deformities of the back/extremities
- ☐ Gout

Neuro
- ☐ Numbness or tingling
- ☐ Severe frequent headaches
- ☐ Abnormal coordination
- ☐ Trouble with speech
- ☐ Forgetfulness/confusion

Skin and Hair Problems
- ☐ Changes in hair/hair loss (major)
- ☐ Wounds that will not heal
- ☐ Persistent rash
- ☐ Change in moles
- ☐ Major skin problems

Psych/Social
- ☐ Feeling blue/discouraged
- ☐ High anxiety/stress
- ☐ Loss of friends
- ☐ Feeling life has no purpose
- ☐ Feeling others are talking about you
- ☐ Feeling fear
- ☐ Hearing voices
- ☐ Marital or relationship problems
- ☐ Early morning awakenings