# Adult Initial Health History

Name _____
First Middle Last

Today's Date_____Date of Birth _____

Address_____

Telephone Number (home)(_____)_____
(cell) (_____)_____
(work) (_____)_____

## Filling out this form

- Answering these questions will help your doctor understand your health and how best to treat you.
- If you need help filling out this form:
    - Bring this form with you to your appointment and a nurse will help you.

OR

    - Call the clinic at [555-1212 ext. 123] before your appointment and someone can help you over the phone.

## Bring to your appointment:

1. This **Initial Health History Form** and any other important **medical records**

2. Your **insurance information**

3. All **your medicines** (prescription, herbal, over-the-counter pills and creams)

**We look forward to working with you!**

## GENERAL HEALTH

1. **Why did you make this appointment**? (Check all that apply.)

☐ regular checkup
☐ first appointment to start care with a new doctor
☐ switching doctors (from whom: _____)
☐ have a specific health problem (if so, explain _____)

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

☐ heart problems
☐ stomach problems
☐ ear, nose, or throat problems
☐ high blood pressure
☐ diabetes
☐ depression/emotional problems
☐ joint problems
☐ Other(s) – please explain_____

_____

3. How would you **describe your health**?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

4. Are you taking any **prescription medicines**?

☐ Yes. Please list your medicines below OR ☐ I brought my pill bottles or a 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 or 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.)

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

☐ Pain reliever (for example: Tylenol, Advil, Motrin, Aleve, aspirin)
☐ Vitamins
☐ Antacid (for example: Tums, Prilosec)
☐ Herbal medicine (please list) _____
☐ Other (please list) _____
☐ None - I do not take any over-the-counter medicines regularly.

6. 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.)
☐ 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 |
| | |
| | |
| | |

7. Do you get an **allergic reaction (bad effect)** from any of the following? (Check all that apply)
☐ latex (rubber gloves)
☐ grass or pollen
☐ eggs
☐ shellfish
☐ Other (please describe) _____
☐ No - I have no allergies that I know of.

8. Have you ever been a **patient in a hospital** overnight?
☐ Yes. (If yes, explain EACH reason and when.)
☐ No, I have never been a patient in a hospital. (If no, go to question #9)

| **I was in the hospital because:** | **When** |
|---|---|
| **Example:** Heart Attack | 6 years ago |
| | |
| | |
| | |
| | |

9. Have you ever had a **colonoscopy** (a test to look at your insides by sending a camera through your bottom)?..... ☐ Yes ☐ No
When _____

10. Have you ever received a **blood transfusion** (when you are given extra blood)? ..... ☐ Yes ☐ No
When_____

## FOR WOMEN ONLY

11. Have you ever been **pregnant**? ..... ☐ Yes ☐ No
How many times?_____
How many children have you given birth to?_____

12. Have you had a **PAP smear**? ..... ☐ Yes ☐ No
Date of last one _____

13. Have you ever had a **PAP smear that was not normal**? ..... ☐ Yes ☐ No

14. Have you had a **mammogram** (breast x-ray)?..... ☐ Yes ☐ No
Date of last one_____

## SHOTS

15. When was your last **Tetanus shot**?.....Year_____ ☐ never ☐ don't know

16. When was your last **Pneumonia shot**?..... Year_____ ☐ never ☐ don't know

17. When was your last **Flu shot**?..... Year_____ ☐ never ☐ don't know

## SOCIAL HISTORY

18. Circle the **highest grade** you finished in school?

| 1 2 3 4 5 6 7 8 | 9 10 11 12 | GED | 1 2 3 | 1 2 3 4+ |
|---|---|---|---|---|
| Grade School | High School | | Vocational School | College |

19. What **language** do you prefer to speak? ☐ English ☐ Spanish ☐ Other _____

20. How well can you **read**?

☐ Very well ☐ Well ☐ Not well ☐ I can not read

21. **What do you do during the day**?
☐ Work full-time
☐ Work part-time
☐ Attend school
☐ Take care of children at home
☐ Go out most days (shop, visit, appointments)
☐ Stay home most days
☐ Other_____

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

☐ No (if no, go to question #23.)

☐ Yes

a. When did you start?_____

b. How much per week? _____

c. Have you quit?..... ☐ No ☐ Yes, when_____

d. Do you want to quit?..... ☐ No ☐ Yes ☐ Already Quit

23. Do you drink **alcohol**?

☐ No (if no, go to question #24.)

☐ Yes

a. Have you ever felt you ought to cut down on your drinking? ☐ Yes ☐ No

b. Have people ever annoyed you by criticizing your drinking? ☐ Yes ☐ No

c. Have you ever felt bad or guilty about your drinking? ..... ☐ Yes ☐ No

d. Have you ever had a drink first thing in the morning? ..... ☐ Yes ☐ No

24. Are you ☐ Single ☐ Married ☐ Partnered ☐ Divorced or Separated ☐ Widowed?

25. Who lives in your house?_____

_____

26. Do you have **sex** with ☐ men ☐ women ☐ both ☐ neither

27. Do you have any **beliefs or practices from your religion, culture, or otherwise** that your doctor should know? For example:

☐ I am a **Jehovah's Witness** and do not accept blood/blood products.

☐ I **do not use birth control** because of personal or religious beliefs.

☐ I **fast** (go without food) for periods of time for personal or religious reasons.

☐ I am a **vegetarian** (do not eat meat.)

☐ I am a **vegan** (do not eat anything that comes from an animal.)

☐ Other special diets or eating habits. (Please describe.) _____

☐ I use traditional medicines or treatments, such as acupuncture or herbs.

☐ Other beliefs_____

☐ **No**, I have no beliefs or practices that need to be included in my care.

28. Check any of the following things you use to **help you walk**.

☐ Cane ☐ Walker ☐ Wheelchair

☐ Other _____

☐ I do not need any help walking

29. Check any of the following types of **help at home** you receive (paid help or family and friends).

☐ Help with cleaning/laundry.
☐ Help with shopping.
☐ Help with personal care (bathing, dressing).
☐ Help with taking my medications.
☐ I do not use any help at home.

30. In the past year, have you been **emotionally or physically abused** by your partner or someone important to you?..... ☐ Yes ☐ No

31. In the past year have you been **hit, pushed, shoved, kicked or threatened** by a partner or someone important to you?..... ☐ Yes ☐ No

32. **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 <u>each day</u>?** |
|---|---|---|
| ☐ walking<br>☐ biking<br>☐ swimming<br>☐ weight training<br>☐ yoga<br>☐ other<br>☐ I do not exercise | ☐ once per week<br>☐ twice per week<br>☐ 3 times a week<br>☐ 4 times a week<br>☐ 5 times a week<br>☐ 6 times a week<br>☐ 7 times a week or more | ☐ less than 15 minutes<br>☐ 15-30 minutes<br>☐ 30 – 45 minutes<br>☐ 45 minutes – 1 hour<br>☐ 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<br>☐ Cancer ☐ other: _____ |
| Father: | ☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems<br>☐ Cancer ☐ other: _____ |
| Sisters: | ☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems<br>☐ Cancer ☐ other: _____ |
| Brothers: | ☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems<br>☐ Cancer ☐ other: _____ |

## HISTORY OF MEDICAL CONDITIONS

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

- ☐ Anemia (low iron blood)
- ☐ Asthma (wheezing)
- ☐ Diabetes (sugar)
- ☐ Heart Trouble
- ☐ Hemorrhoids (piles)
- ☐ Cancer
- ☐ Hepatitis (yellow jaundice)
- ☐ Tuberculosis (TB)
- ☐ Liver Trouble
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Ulcers
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Skin problems
- ☐ Depression (feeling down or blue)
- ☐ Epilepsy (fits, seizures)
- ☐ Anxiety (nerves, panic attacks)
- ☐ VD, STD (syphilis, gonorrhea, chlamydia, HIV)
- ☐ Other_____

## REVIEW OF SYMPTOMS

| | | YES | NO |
|---|---|---|---|
| **Sleeping** | Do you **feel tired** a lot? | ☐ yes | ☐ no |
| | Do you have **trouble falling or staying asleep**? | ☐ yes | ☐ no |
| | Do you have **other problems with sleep**? | ☐ yes | ☐ no |
| **Eating** | Have you **lost your appetite** recently? | ☐ yes | ☐ no |
| | Have you **lost weight** in the last year without trying? | ☐ yes | ☐ no |
| | Do you **eat too much** or **have you gained weight** recently? | ☐ yes | ☐ no |
| | Do you have **other problems with eating**? | ☐ yes | ☐ no |
| **Throat** | Do you have **sore throats** a lot? | ☐ yes | ☐ no |
| | Do you have **other problems with your throat**? | ☐ yes | ☐ no |
| **Ears** | Do you have **trouble hearing**? | ☐ yes | ☐ no |
| | Do you wear a **hearing aid**? | ☐ yes | ☐ no |
| | Do you have constant **ringing or noises** in your ears? | ☐ yes | ☐ no |
| | Do you have **other problems with your ears?** | ☐ yes | ☐ no |
| **Back** | Do you have **back pain**? | ☐ yes | ☐ no |
| | Do you have any **other problems with your back**? | ☐ yes | ☐ no |

| | | | |
|---|---|---|---|
| **Eyes** | Do you have **trouble with your vision** or seeing? | ☐ yes | ☐ no |
| | Do you wear **glasses or contacts**? | ☐ yes | ☐ no |
| | Do you have **other problems with your eyes**? | ☐ yes | ☐ no |
| **Nose and Sinuses** | Do you have a **runny or stopped up nose** a lot? | ☐ yes | ☐ no |
| | Do you have **other problems with your nose or sinuses?** | ☐ yes | ☐ no |
| **Teeth and Mouth** | Do you have **sore or bleeding gums**? | ☐ yes | ☐ no |
| | Do you wear **plates or false teeth**? | ☐ yes | ☐ no |
| | Do you have **other problems with your teeth and mouth?** | ☐ yes | ☐ no |
| **Heart or Breathing** | Do you ever have **pain/tightness in your chest** when working or exercising? | ☐ yes | ☐ no |
| | Do you **wake up at night with trouble breathing**? | ☐ yes | ☐ no |
| | Do you have a **racing or skipping heartbeat** at times? | ☐ yes | ☐ no |
| | Do you have **other heart or breathing problems**? | ☐ yes | ☐ no |
| **Bowel movements** | Do you have **bowel movements (poop) that are black, like tar, or bloody?** | ☐ yes | ☐ no |
| | Do you have **any other problems with your bowel movements (poop)?** | ☐ yes | ☐ no |
| **Peeing and Kidney Stones** | Do you have **trouble passing your urine (peeing)?** | ☐ yes | ☐ no |
| | Does it **burn when you pass urine (pee)?** | ☐ yes | ☐ no |
| | Do you have to **pee more than 2 times a night**? | ☐ yes | ☐ no |
| | Do you **leak urine (pee)?** | ☐ yes | ☐ no |
| | Have you ever passed **kidney stones**? | ☐ yes | ☐ no |
| | Do you have any **other problems with your peeing**? | ☐ yes | ☐ no |
| **Joints** | Do you have **swollen or painful joints**? | ☐ yes | ☐ no |
| | Do you have any **other problems with your joints**? | ☐ yes | ☐ no |

| | | | |
|---|---|---|---|
| **Head, Balance, Fever and Weakness** | Do you have **frequent or severe headaches**? | ☐ yes | ☐ no |
| | Have you ever **fainted (passed out)**? | ☐ yes | ☐ no |
| | Have you **lost your balance and fallen** recently? | ☐ yes | ☐ no |
| | Do you have **weakness** in any part of your body? | ☐ yes | ☐ no |
| | Have you had a **fever** within the past month? | ☐ yes | ☐ no |
| | Do you have any **other problems with your head or balance?** | ☐ yes | ☐ no |
| **Emotional Health** | Do you get **upset easily**? | ☐ yes | ☐ no |
| | Do **frightening thoughts** keep coming into your mind? | ☐ yes | ☐ no |
| | Have you ever been **hospitalized for nerves, thoughts or moods**? | ☐ yes | ☐ no |
| | During the past 2 weeks, have you often been bothered by having **little interest or pleasure in doing things**? | ☐ yes | ☐ no |
| | During the past 2 weeks, have you often been bothered by feeling **down, depressed, or hopeless**? | ☐ yes | ☐ no |
| | Do you have any **other problems with your emotional health?** | ☐ yes | ☐ no |
| **Men Only** | Have you ever had **prostate trouble**? | ☐ yes | ☐ no |
| | Do you have any **other male problems**? | ☐ yes | ☐ no |
| **Women Only** | Do you have **pain or lumps in your breast**? | ☐ yes | ☐ no |
| | Do you have unusual **vaginal discharge or itching**? | ☐ yes | ☐ no |
| | Do you or have you taken **hormones (such as birth control pills)**? | ☐ yes | ☐ no |
| | Do you have any **other female problems**? | ☐ yes | ☐ no |