HealthPlus
The Plus makes all the difference.

Adult Health History Form

Name	☐ M ☐ F	DOB	Today's Date

PERSONAL MEDICAL HISTORY: Do you currently have or have had in the past (mark all that apply)

____ Heart disease ____ High Blood Pressure ____ High Cholesterol ____Cancer
____ Diabetes ____ Kidney Disease ____ Thyroid problem ____ Headaches
____ Depression ____ Seizures ____ Stroke ____ Asthma/lung disease
____ Other (specify) _____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, herbs, homeopathic, etc.

Medication Dose (mg/pill) How many times per day

_____
_____
_____
_____
_____

ALLERGIES or reactions to medications: _____

Date of your most recent **IMMUNIZATIONS**:

Hepatitis A _____Hepatitis B _____ Influenza (flu shot) _____ MMR _____ Meningitis _____
Pneumovax (pneumonia) _____Varicella (chicken pox) shot or illness _____
Tdap _____ Td_____ Herpes Zoster _____ Other_____

HEALTH MAINTENANCE SCREENING TESTS:

BMI _____
Lipid (cholesterol) _____ Date_____ Abnormal? ☐ Yes ☐ No
Sigmoidoscopy____or Colonoscopy _____ Date_____ Abnormal? ☐ Yes ☐ No
Women: Mammogram ____ Date _____ Abnormal? ☐ Yes ☐ No
Pap Smear ____ Date _____ Abnormal? ☐ Yes ☐ No Bone Scan ____ Date ____ Abnormal? ☐ Yes ☐ No
Men: PSA (prostate) _____ Date ____ Abnormal? ☐ Yes ☐ No

SURGICAL HISTORY: Please list all prior operations (with dates):

_____

FAMILY HISTORY: Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions, if deceased due to a condition please put age at death:

Heart Disease _____ High Blood Pressure _____
High Cholesterol _____ Stroke _____
Cancer, specify type _____ Thyroid disease _____
Diabetes _____ Bleeding or clotting disorder _____
Asthma/COPD _____ Genetic Disorders _____
Depression/Suicide _____ Alcoholism/Drug Overdose _____
Other: _____

SOCIAL HISTORY

Tobacco Use

Cigarettes ☐ Never ☐ Quit Date _____
☐ Current Smoker: packs/day _____# of yrs ____
Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
Are you interested in quitting? ☐ No ☐ Yes

Alcohol Use

Do you drink alcohol? ☐ No ☐ Yes
#drinks/week_____
If yes:
Have you ever felt you should cut down on your drinking? ☐ No ☐ Yes
Have people ever annoyed you by nagging about your drinking? ☐ No ☐ Yes
Have you ever felt guilty about your drinking? ☐ No ☐ Yes
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ☐ No ☐ Yes

Drug Use

Do you use any recreational drugs? ☐ No ☐ Yes
If yes, what kind? _____
Have you ever used needles to inject drugs?
☐ No ☐ Yes

Sexual Activity

Sexually active: ☐ No ☐ Yes ☐ Not currently
How many sexual partners have you had in the last 12 months? _____ In your lifetime? _____
Birth Control Method: _____ ☐ None needed
Have you ever had any Sexually Transmitted Diseases (STDs)? ☐ No ☐ Yes

Women's Health History

Pregnancies _____ # Deliveries _____
#Abortions _____ # Miscarriages _____
Age at start of periods: _____
Age at end of periods: _____

OTHER CONCERNS

Caffeine Intake: ☐ None ☐ Coffee/tea/soda _____ cups/day

Weight: Are you satisfied with your weight? ☐ No ☐ Yes

Diet: How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Exercise: Do you exercise regularly?
What kind of exercise? _____
How long? (minutes) _____ How often? _____

Safety: Do you use a bike helmet? ☐ No ☐ Yes ☐ N/A
Do you use seatbelts consistently? ☐ No ☐ Yes
Do you have firearms at home? ☐ No ☐ Yes
Does your house have a working smoke detector?☐ No☐ Yes

Relationships:

Conflict in your family or relationships, sometimes handled by pushing, hitting or cruelty? ☐ No ☐ Yes
Often feeling down, depressed or hopeless during the past month? ☐ No ☐ Yes
Often have little interest or pleasure in doing things in the past month? ☐ No ☐ Yes

Have you completed a living will or durable power of attorney for health care? ☐ No ☐ Yes

Patient Signature _____ Reviewed by_____
Date: _____