# ADULT HEALTH DATABASE

Date: ______________________
Name: ______________________________ DOB: ____________ Previous Last Name(s): __________________
Address: ______________________________________________________________________
Phone/Email: Home ______________ Work _____________ Cell ____________ Email __________________
Emergency Contact: Name _________________________________Phone _________________________________

## MEDICATIONS

Please include prescription and non-prescription medications used on a regular basis (Including aspirin, vitamins, laxatives, birth-control, injections, alternative medicines, etc.) Add extra sheet if needed.

**Name:** **Dose:** **Frequency:** **Used for:**

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

## ALLERGIES/SENSITIVITIES

Drug or Substance: Reaction: When:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

## PERSONAL & FAMILY HEALTH HISTORY

| | Self | Mother | Father | Sibling | | Self | Mother | Father | Sibling |
|---|---|---|---|---|---|---|---|---|---|
| **Surgeries** | | | | | **Colon/Bowel Disease** | | | | |
| **Heart Disease** | | | | | **Fibromyalgia** | | | | |
| **High Cholesterol** | | | | | **History of Blood Clots** | | | | |
| **High Blood Pressure** | | | | | **Osteoporosis** | | | | |
| **Stroke** | | | | | **Anemia** | | | | |
| **Cancer** | | | | | **Bleeding Disorder** | | | | |
| **Diabetes** | | | | | **Depression** | | | | |
| **Thyroid Problem** | | | | | **Anxiety** | | | | |
| **Asthma** | | | | | **Alcohol Problem** | | | | |
| **Emphysema** | | | | | **Substance/Drug Problem** | | | | |
| **Allergies** | | | | | **Seizures** | | | | |
| **Gout** | | | | | **Migraines** | | | | |
| **Arthritis** | | | | | **Glaucoma/Eye Disease** | | | | |
| **Kidney Disease/Stones** | | | | | **Major Accident** | | | | |
| **Liver Disease/Hepatitis** | | | | | **Blood Transfusion** | | | | |
| **Ulcer** | | | | | **Recurrent Back Pain** | | | | |
| **Heartburn/GERD** | | | | | **Orthopedic Problems** | | | | |
| **Gynecological Problems** | | | | | **Skin Disease** | | | | |

Explanation of any checked that pertain to you:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

## SOCIAL HISTORY

Current Marital Status: Single□ Married□ Separated□ Divorced□ Widowed□
Do you smoke cigarettes? □Yes □No If yes, how many per day? ___________________
Do you chew tobacco? □Yes □No If yes, how much per day? ___________________
Did you smoke in the past? □Yes □No If yes, date you quit: ___________________
Do you consume alcohol? □Yes □No
If yes, what? ____________How much? ____________How often? ______________
Has anyone ever expressed concern about your drinking? □Yes □No
Do you often drink alone? □Yes □No
Is alcohol a factor in any problems you may have experienced (personal, employment, legal)? □Yes □No
Do you feel your overall health would be better if you stopped drinking? □Yes □No
Would you like more information or help with quitting drinking? □Yes □No
Do you drink coffee, tea, or soda containing caffeine? □Yes □No How much daily? ____________
Do you or have you used recreational drugs? □Yes □No If yes, what kind and how much?____________
Do you exercise regularly? □Yes □No If yes, how and how often? ______________
Current Occupation: ______________ Current Employer: ___________________
Hobbies: ___________________________________________
Do you follow any special diet? □Yes □No Type: ___________________
Military History: ______________ Religion: ___________________
Sexual Orientation: ______________ Birthplace: ___________________
Highest Education Level: Elem□ HS□ College□ Grad-Degree□

## HOUSEHOLD MEMBERS

Name Age Relationship

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

Any major changes in your family/personal life?
□Yes □No ______________________

## IMMUNIZATION STATUS

| Have you had? | Date of last | Results | Have you had? | Date of last | Results |
|---|---|---|---|---|---|
| Tetanus (last booster) | | | MMR (Measles, Mumps, Rubella) | | |
| Influenza (yearly) | | | Varicella (Chicken Pox) | | |
| Pneumovax (pneumonia) | | | Hepatitis B (3-Shot Series) | | |
| Polio | | | Tuberculosis skin test | | |

## SAFETY

Do you regularly use the following?
Seat belts: □Yes □No
Helmet (bicycle, motorcycle, sports): □Yes □No
Ear/Eye Protection (when needed): □Yes □No
Sunscreen (when needed): □Yes □No
Are there smoke detectors in your home? □Yes □No
If you have guns in your home, are they unloaded and safely locked up? □Yes □No
Are you, or have you been, a victim of abuse? □Yes □No
Do you have any safety concerns you would like help with?___________ □Yes □No

**ADVANCE DIRECTIVE**

Name of Healthcare Proxy/Durable Power of Attorney for healthcare: ________________________________

If you have prepared an Advance Directive (Living Will, Health Care Proxy) please provide us with a copy. If you would like more information, please indicate ________________________________________________

**OB GYN HISTORY- WOMEN ONLY**

Age period began:________ How often:_______(days)
Number of days your period lasts: _________
Last period date:____________
If your period has stopped what year:_____________
Number of pregnancies:____ Number of births:______
Number of miscarriages: _______
Number of elective abortions:_______
Type of birth control now used:_________________
Did your mother take DES or hormones while pregnant with you? □Yes □No □Unknown
Have you ever been treated for venereal disease/sexually transmitted disease? □Yes □No
Have you ever had, or currently undergoing, hormonal replacement therapy? □Yes □No
Have you ever had an abnormal pap? □Yes □No
Have you had a colposcopy? □Yes □No

**Do you have any problems or concerns with any of the following?**

Heavy Flow? □Yes □No
Bleeding between periods? □Yes □No
Bleeding or spotting after intercourse? □Yes □No
Recurrent vaginal discharge or itch? □Yes □No
Infertility? □Yes □No
Menopausal Symptoms? □Yes □No
Premenstrual symptoms? □Yes □No
Sexual function? □Yes □No
Have you recently (past 5 yrs) had multiple sexual partners? □Yes □No

**HISTORY- MEN ONLY**

Do you perform testicular self-examination? □Yes □No
Have you recently (past 5 yrs) had multiple sexual partners? □Yes □No
Have you ever been treated for venereal disease/sexually transmitted disease? □Yes □No
Have you had a vasectomy? □Yes □No

**Do you have any problems or concerns with any of the following?**

Infertility? □Yes □No
Scrotum or testicles? □Yes □No
Decrease in stream? □Yes □No
Prostate? □Yes □No
Impotence/sexual function? □Yes □No
Nighttime urination? □Yes □No
Change in pattern of urination? □Yes □No

**GENERAL HEALTH MAINTENANCE**

| **Have you undergone?** | **Date of last** | **Results** | **Would you like to discuss?** |
|---|---|---|---|
| Physical Exam | | | |
| Pap Smear | | | |
| Mammogram | | | |
| Colonoscopy | | | |
| Other test for colon cancer | | | |
| Eye Exam | | | |
| Hearing Exam | | | |
| Dental Exam | | | |
| Cholesterol Screening | | | |
| Prostate cancer blood test(PSA) | | | |
| Bone mineral density test | | | |
| Testing for HIV/AIDS/Hep C | | | |
| | | | |

Is there some other question you wish answered today if there is time? ______________________

________________________________________________________________________________

Do you need medication refills today? …………………………………… YES NO

Are there any forms you request to be completed today? ..……….............. YES NO

Would you like a nurse to accompany you in your visit today? YES NO

Please indicate if you are having any of the following symptoms:

| **Constitutional** | Old | New |
|---|---|---|
| Feeling tired | | |
| Fever / Chills | | |
| Recent weight change | | |
| **Eyes** | Old | New |
| Visual changes | | |
| Red eyes | | |
| **Ear, Nose, Throat, Mouth** | Old | New |
| Ear pain | | |
| Nasal congestion/Post-nasal drip | | |
| Sore throat | | |
| Sores in mouth | | |
| **Cardiovascular** | Old | New |
| Chest painful or tight | | |
| Palpitations / racing heart | | |
| Swelling in feet or ankles | | |
| **Respiratory** | Old | New |
| Coughing | | |
| Wheezing | | |
| Shortness of breath | | |
| **GI** | Old | New |
| Decreased appetite | | |
| Abdominal pain | | |
| Nausea or vomiting | | |
| Diarrhea | | |
| Constipation | | |
| Heartburn | | |
| Blood in stool | | |
| **Urinary** | Old | New |
| Pain during urination | | |
| Frequency of urination | | |
| Blood in urine | | |

| **Musculoskeletal** | Old | New |
|---|---|---|
| Neck pain | | |
| Back pain | | |
| Joint pain | | |
| **Skin** | Old | New |
| Skin rash | | |
| Changing mole | | |
| **Neurologic** | Old | New |
| Headache | | |
| Dizziness | | |
| Numbness | | |
| Decrease in strength | | |
| **Psychiatric** | Old | New |
| Sleep disturbances | | |
| Depression | | |
| Anxiety | | |
| **Endocrine** | Old | New |
| Excessive sweating | | |
| Sweating heavily at night | | |
| Excessive thirst | | |
| Feeling hot or cold | | |
| **Hem/Lymph** | Old | New |
| Easy bruising | | |
| Swelling | | |
| **Allergies** | Old | New |
| Food allergies | | |
| Seasonal allergies | | |
| **Gynecological (women only)** | Old | New |
| Irregular vaginal bleeding | | |
| Vaginal discharge | | |
| Vaginal pain, itching or burning | | |
| New/changing breast lump | | |