

# ADULT HEALTH HISTORY

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ GENDER M  F

What are your goals for your health?

## Current Concerns

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## Other Healthcare Practitioners

1. \_\_\_\_\_
2. \_\_\_\_\_

## Past Medical Diagnoses, surgeries, hospitalizations

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Date of last: Physical exam \_\_\_\_\_

Lab tests \_\_\_\_\_

Dental visit \_\_\_\_\_

Last tetanus shot \_\_\_\_\_

## OTHER MEDICAL HISTORY AND REVIEW OF SYSTEMS

### GENERAL

- Fatigue
- Weight change
- Difficulty losing wt
- Fever
- Night sweats
- Headache
- Eating disorder
- Addiction
- Slow healing
- Fainting/ dizziness
- Insomnia

- Hearing loss
- Ringing in ears
- Post nasal drip
- Sinus congestion
- Hay fever
- Bloody nose
- Cold sores
- Canker sores
- Bleeding gums
- Sore throat
- Bad breath
- Difficult to swallow

- Hemorrhoids
- Blood in stool
- Leaking stool
- Black stools
- Abdominal pain
- Change in stool
- Gall stones
- Hernia
- Low blood sugar

### MIND

- Difficulty coping
- Excessive stress
- Depressed
- Anxiety
- Panic attacks
- Forgetful
- Poor concentration
- Bad dreams
- Bipolar disorder
- Negative thoughts - persistent

### ENDOCRINE

- Diabetes
- Thyroid disorder
- Too hot or cold
- Nipple discharge
- PMS (women)
- Always thirsty

### URINARY

- Painful urination
- Weak urine stream
- Blood in urine
- Kidney infections
- Nighttime urination
- Leaking urine
- Bladder infection

### MEN ONLY

- Penile discharge
- Erectile dysfunction
- Prostate problems
- Testicular pain
- Lump on testicle

### SEXUALITY

- Low libido
- History STD
- Pain during sex
- Difficult to orgasm
- Sexual abuse

### SKIN

- Rash
- Itching
- Dryness
- Color changes
- Moles
- Excessive sweat
- Hair loss
- Heavy body hair
- Ridges in nails
- White spot on nails

### LUNGS

- Cough
- Wheezing
- Short of breath
- Asthma
- Bronchitis
- Painful breathing

### MUSCULOSKELETAL

- Joint pain
- Joint deformity
- Muscle tension
- Back pain

### WOMEN ONLY

#### GYN HISTORY

- Age at first period? \_\_\_\_\_
- How often do you have a period? \_\_\_\_\_
- How many days do you bleed? \_\_\_\_\_
- Have you ever had a breast lump? \_\_\_\_\_

### OTHER

- Hospitalized
- Surgery
- Blood transfusion

### EENT

- Eye pain
- Eye discharge
- Vision changes
- Glasses/ contacts
- Double vision
- Glaucoma
- Cataract
- Ear infections

### HEART

- Heart murmur
- Palpitations
- Chest pain
- Swelling
- Anemia

### NEUROLOGICAL

- Numbness
- Tingling
- Weakness
- Loss of balance
- Loss of smell/ taste
- Seizure
- Shooting pains

### GASTROINTESTINAL

- Heartburn/ reflux
- Vomit blood
- Stomach pain
- Constipation
- Diarrhea

### PREGNANCY HISTORY

- YES  NO Have you ever been pregnant?
- # Abortions: \_\_\_ miscarriages? \_\_\_ adoptions \_\_\_
- Date of Births:
1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_

## FOUNDATIONS OF WELLNESS

Describe your diet:

Describe your sleep:

\_\_\_\_\_

\_\_\_\_\_

Number of servings per day:

\_\_\_\_\_ Meat  
\_\_\_\_\_ Fish  
\_\_\_\_\_ Dairy  
\_\_\_\_\_ Fruit  
\_\_\_\_\_ Vegetables  
\_\_\_\_\_ Whole grains  
\_\_\_\_\_ Eggs  
\_\_\_\_\_ Sweets/soda

Do you spend time outdoors regularly?  YES  NO

How much do you weigh now? \_\_\_\_\_

Weight at age 20 \_\_\_\_\_

How often do you have a bowel movement? \_\_\_\_\_

Do you sweat easily?  YES  NO

## SOCIAL HISTORY

Who do you turn to for support? \_\_\_\_\_

Who lives in your home? \_\_\_\_\_

What causes stress for you? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

YES  NO Is your home a sanctuary for you?

YES  NO Do you take vacations?

YES  NO Have you experienced domestic violence?

Daily  
Weekly  
Monthly  
Rarely or NO

Habits:

Alcohol

Tobacco

Recreational Drugs

Caffeine

Exercise

Toxic exposures through work or hobbies

## FAMILY HISTORY

High blood pressure \_\_\_\_\_  
 Tuberculosis \_\_\_\_\_  
 Heart disease \_\_\_\_\_  
 Thyroid disorder \_\_\_\_\_  
 Diabetes \_\_\_\_\_  
 Stroke \_\_\_\_\_  
 Kidney Disease \_\_\_\_\_  
 Arthritis \_\_\_\_\_  
 Allergy \_\_\_\_\_  
 Cancer \_\_\_\_\_  
 Obesity \_\_\_\_\_  
 Autoimmune disease \_\_\_\_\_  
 Epilepsy \_\_\_\_\_  
 Substance Abuse \_\_\_\_\_  
 Osteoporosis \_\_\_\_\_  
 Other \_\_\_\_\_

## MEDICATIONS

Current Prescription Medications

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Current Over the Counter Medications

1. \_\_\_\_\_

2. \_\_\_\_\_

Current vitamins, herbs, homeopathics...

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Have you had a tetanus booster in the last 10 years?  YES  NO

## ALLERGIES:

Drug \_\_\_\_\_  
 Environmental \_\_\_\_\_  
 Food \_\_\_\_\_

## JOY

What practices or activities do you use to sustain your health and well being? (spiritual, religious, inspirational?)

Reviewed by \_\_\_\_\_

Date \_\_\_\_\_