

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 Vegetables
 Fish Whole grains
 Dairy Eggs
 Fruit 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? _____

	Daily	Weekly	Monthly	Rarely or NO	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Habits:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recreational Drugs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caffeine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Toxic exposures through work or hobbies

YES NO Is your home a sanctuary for you?
 YES NO Do you take vacations?
 YES NO Have you experienced domestic violence?

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 _____