HIGHLAND FAMILY MEDICINE
ADULT HEALTH HISTORY

PLEASE PRINT CLEARLY OR TYPE DATE_____ Chart Number_____

Name: _____ Male_____ Female_____ Birth Date _____

Birthplace_____

Address: _____ Home Phone_____ Cell/Other_____

Education: Highest level of school completed: Elementary___ High School ___ College ___ Other_____

Occupation: _____

How would you rate your overall health and well-being? Excellent ___ Good ___ Fair ___ Poor ___

What are your major health concerns?

_____

HEALTH FACTORS

1. Do you use tobacco now? YES ____ NO ____
   _____ #cigarettes per day
   _____ #pipes/cigars per day
   _____ #chewing/smokless tobacco per day

2. If you do not now use tobacco, have you ever used tobacco? YES ____ NO ____

3. Do you regularly eat? Breakfast ____ Lunch ____ Dinner ____ Snacks/Fluids ____

4. Do you consider yourself? Correct weight ____ Underweight ____ Over weight ____

5. Do you drink caffeinated beverages? YES ____ NO ____
   (Example: coffee, tea, colas, other sodas)

6. Are you on a special diet? YES ____ NO ____
   Explain: _____

7. Do you exercise regularly? YES ____ NO ____
   How often? _____ What type of exercise? _____

8. Has drinking or drugs ever caused you a problem? YES ___ NO ____
   (Health, legal, driving, family, or work)

9. Do you wear a seatbelt when you drive? Always ____ Usually ____ Occasionally ____ Never ____

10. Has your job or hobby ever involved exposure to a large amount of: paints, varnishes, chemical solvents, loud noise, asbestos, fiberglass, gasoline powered tools or motors, pesticides, cleaning fluids, soldering, or radiation?
    (If yes, please circle the appropriate agent) YES ____ NO____

11. **For Men**:

Do you examine your testicles regularly? YES ____ NO ____

What is your method of pregnancy prevention? _____

How do you protect yourself against sexually transmitted diseases? _____

12. For Women:

Do you examine your breasts each month? YES ____ NO ____

Have you ever uses oral contraceptives /birth control pills? YES ____ NO ____

# of pregnancies? _____ # of children? _____

Have you ever used an IUD (Intrauterine Device)? YES ____ NO ____

What is your method of pregnancy prevention? _____

How do you protect yourself against Sexually Transmitted Diseases? _____

Have you completed your menopause? Age:_____ YES ____ NO ____

Do you use hormone replacement therapy? YES ____ NO ____

HEALTH PROBLEMS

13. Have you ever had an allergic reaction or side effect to any medicines? YES ____ NO ____

Name(s) _____

14. Have you ever had any other allergic reactions? YES ____ NO ____

(Bee sting, asthma, severe poison ivy, specific food, injections)

Explain _____

15. Have you ever been hospitalized? YES ____ NO ____

Please list all. (Medical and surgical, biopsies, fractures, obstetric/gynecologic and psychiatric)

Nature of Problem	**Date**	**City & State**	**Hospital**

16. Please check **previous** box if you had the condition or problem in the past.

Check the **now** box if you currently have any of the following.

	Previous	**Now**		**Previous**	**Now**
Glaucoma			Seasonal Allergy/Hay Fever		
Thyroid problems			Alcoholism		
Increased cholesterol			Bleeding Tendency		
Diabetes			Polio		
Lung problems			Rheumatic Fever		
Abnormal chest x-ray			Scarlet Fever		
Abnormal cardiogram-EKG			Sinus or ear infection		
Heart Murmur			Tuberculosis		
High Blood Pressure			Pneumonia or Bronchitis		
Heart problems			Syphilis		
Stroke			Gonorrhea		

	Previous	Now		Previous	Now
Bowel problems			Other sexually transmitted disease		
Hepatitis or Liver problems			Depression or anxiety		
Ulcer			Drug addiction		
Gall Bladder disease			Mental health problems		
Headaches			Work related disabilities		
Back pain			Cancer		
Gout			HIV infection		
Epilepsy			Blood transfusion		

17. Please check the symptoms which you have had during the **<u>past year</u>** and symptoms which are of concern to you **<u>now</u>**.

	Previous	Now		Previous	Now
Skin lump, rash or sores			Loss of consciousness		
Mole change (color or size)			Loss of balance/falls		
Eye problems			Speech difficulties		
Dental or denture problems			Back pain		
Hoarseness			Shortness of breath		
Excessive thirst or appetite			Chest pain		
Coughing or vomiting blood			Swollen ankles		
Wheezing			Weight change		
Chronic cough			Difficulty sleeping		
Irregular heartbeat			Excessive tiredness		
Leg pain with exertion/or rest			Loss of appetite		
Difficulty swallowing			Unusual bleeding or bruising		
Heartburn			Feelings of tension or unhappiness		
Nausea or vomiting			Difficulty concentrating		
Diarrhea or constipation			Problems with sexual functions		
Black or bloody stool			Problems with infertility		
Hemorrhoids			**For men**: sores or discharge from penis		
Changes in bowel habits			Pain or swelling in testicles		
Difficulty urinating			**For women**: unexpected vaginal bleeding		
Cloudy or bloody urine			Vaginal discharge		
Joint or muscle pain			Hot flashes		
Dizziness			Pain or lump in breast		
Weakness or paralysis			Discharge from nipples		
Tingling or numbness			Difficulty with menstrual period		
Frequent or severe headaches					

18. **MEDICATIONS**

Please list the names of all medications that you now take:

_____

_____

_____

_____

19. FAMILY HISTORY

Check and indicate which family member(s) has or had the following health problems:
(**M**other, **F**ather, **B**rother, **S**ister, **A**unt, **U**ncle, **G**randparent)

_____ Bleeding tendency
_____ Birth defects
_____ Stroke
_____ Miscarriage
_____ Cholesterol
_____ Diabetes (sugar)
_____ Heart Disease
_____ Glaucoma
_____ Cancer
_____ Emphysema
_____ High Blood Pressure
_____ Tuberculosis
_____ Mental illness
_____ Kidney disease
_____ Alzheimer's
_____ Alcohol or Drug addiction
_____ DES (mother)

other family health problems: _____

20. Please list family members: parent(s), brother(s), sister(s), spouse, children, and their current health.

Name	**Relationship**	**If alive, indicate health: good-poor**	**If dead, indicate age and cause of death**

21. Do you live with others? YES _____ NO _____
Describe with whom? _____

OTHER HEALTH PROBLEMS

22. Please list other health care professionals seen within the last 3-5 years.

Physician, Dentist, or Therapist Name and Address	**Specialty**	**Last Visit**

TOPICS YOU WISH TO DISCUSS

23. Check the items you would like to discuss with your health care provider:

_____ Family
_____ Work
_____ Exercise
_____ Birth Control
_____ Parenting
_____ Retirement
_____ Stress
_____ Sexual function
_____ Depression
_____ Infertility
_____ Alcohol use
_____ Anger
_____ Services for elderly
_____ Living Will/Health Care Proxy
_____ Grieving
_____ Anxiety
_____ Smoking
_____ Osteoporosis
_____ HIV/Aids
_____ Diet/food intake
_____ Emotional Control
_____ Premenstrual Syndrome
_____ Sexually transmitted diseases
_____ Cancer signs

Other: _____