Breezewood Family Healthcare, P.A.

Adult Health History Form

____
Name *Date*

Your answers on this form will help your practitioner better understand your medical concerns and conditions. This form will not be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. **Thank you!**

Age: ________________ How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Main reason for today's visit: ____

Other concerns: ____

Who was your previous primary care provider? ____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.		
Constitutional	**Respiratory**	**Skin**
☐ Recent fevers/sweats	☐ Cough/wheeze	☐ Rash
☐ Unexplained weight loss/gain	☐ Coughing up blood	☐ New or change in mole
☐ Unexplained fatigue/weakness		
	Gastrointestinal	**Neurological**
Eyes	☐ Heartburn/reflux	☐ Headaches
☐ Change in vision	☐ Blood or change in bowel movement	☐ Migraines
	☐ Nausea/vomiting/diarrhea	☐ Memory loss
Ears/Nose/Throat/Mouth	☐ Pain in abdomen	☐ Fainting
☐ Difficulty hearing/ringing in ear		
☐ Hay fever/allergies/congestion	**Genitourinary**	**Psychiatric**
☐ Trouble swallowing	☐ Painful/bloody urination	☐ Anxiety/stress
	☐ Leaking urine	☐ Sleep problem
Cardiovascular	☐ Nighttime urination	
☐ Chest pains/discomfort	☐ Discharge: penis or vagina	**Blood/Lymphatic**
☐ Palpitations	☐ Unusual vaginal bleeding	☐ Unexplained lumps
☐ Short of breath with exertion	☐ Concern with sexual functions	☐ Easy bruising/bleeding
Breast	**Musculoskeletal**	**Endo**
☐ Breast lump	☐ Muscle/joint pain	☐ Cold/heat intolerance
☐ Nipple discharge	☐ Recent back pain	☐ Increase thirst/appetite

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless?

☐ Yes ☐ No

Allergies to food/environmental or reactions to medications:

Allergy/Medication	Reaction

Dates of your most recent **IMMUNIZATIONS**:

Hepatitis A________ Hepatitis B_________ Influenza__________ MMR_____________ Pneumova_________
Meningitis_________ Tetanus (Td)_______ Varicella (chicken pox) or illness___________ Tdap_____________

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol)_______________________ Date__________________________ Abnormal? ☐ Yes ☐ No

Sigmoidoscopy ☐ or Colonoscopy ☐ Date ________ Where _________________ With whom ______________

Abnormal? ☐ Yes ☐ No

Women: Mammogram ☐ Date _______ Where________________________ With whom ___________________

Abnormal? ☐ Yes ☐ No

Pap Smear ☐ Date _______ Where________________________ With whom ___________________

Abnormal? ☐ Yes ☐ No

Dexascan (osteporosis) Date _________ Where _______________________________ Abnormal? ☐ Yes ☐ No

Men: PSA (prostate) ☐ Date ________ Where________________________ With whom ___________________

Abnormal? ☐ Yes ☐ No

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates).

☐ Heart disease: ________________ ☐ High blood pressure: ______________ ☐ High cholesterol ________________

☐ Diabetes (specify type) ___________________ ☐ Thyroid problem ____________________________

☐ Asthma/Lung disease ______________ Other: (specify): ______________ ☐ Kidney disease: ___________________

☐ Cancer: (specify): ____

Have you had any of the following childhood illnesses? ☐ Chicken pox ______________ ☐ Measles ______________

☐ Mumps ________________ ☐ Asthma ________________ ☐ Other illnesses ________________

Do you see any specialist currently or in the past? ☐ Yes ☐ No (Please list below.)

____
____
____

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

____
____
____
____

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Medical Condition	Mom	Dad	Sis.	Bro.	Dau.	Son	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sis.	Mom's Bro.	Dad's Sis.	Dad's Bro.
Deceased:														
Cause of Death:														
Alcoholism														
Bleeding problems														
Cancer, Breast														
Cancer, Colon														

Medical Condition	Mom	Dad	Sis.	Bro.	Dau.	Son	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sis.	Mom's Bro.	Dad's Sis.	Dad's Bro.
Cancer, Melanoma														
Cancer, Ovary														
Cancer Prostate														
Heart Attack/Heart Disease														
Depression														
Diabetes, on insulin shots														
Diabetes, not on insulin														
High Cholesterol														
High Blood Pressure														
Stroke														
Substance abuse														
Thyroid disorders														

SOCIAL HISTORY

Tobacco Use

Cigarettes: ☐ Never ☐ Quit If quit: Date or how long: __________ How may packs/day? ________

☐ Current Smoker: packs/day _________ # of yrs ___________

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ No ☐ Yes If yes what have your tried in the past? ____________________________

Alcohol Use

Do you drink alcohol? ☐ No ☐ Yes # drinks/week ___________

Is your alcohol use a concern for you or others? ☐ No ☐ Yes

Drug Use

Have you ever used any recreational drugs? ☐ No ☐ Yes Currently use? ☐ No ☐ Yes

If yes, what? ______________________________________

Have you ever used needles to inject drugs? ☐ No ☐ Yes

Sexual Activity

Sexually active: ☐ Yes ☐ No ☐ Not currently How long? _____________

Current sex partner(s) is/are: ☐ male ☐ female # of current partners ______ # of lifetime partners _______________

Birth control method: ☐ None needed What type of birth control if currently using? ______________________________

Have you ever had any sexually transmitted diseases (STDs)? ☐ No ☐ Yes If yes, what ________________________

Was it treated ☐ No ☐ Yes

Are you interested in being screened for sexually transmitted diseases? ☐ No ☐ Yes

OTHER CONCERNS

Pets: ☐ Yes ☐ No What kind? ____

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

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

Exercise: Do you exercise regularly? ☐ No ☐ Yes

What kind of exercise? ____

How long (minutes) __________________ How often? ___________________________________

If you do not exercise, why? ____

Safety:

Do you use seatbelts consistently? ☐ No ☐ Yes

Is violence at home a concern for you? ☐ Yes ☐ No

Have you ever been abused? ☐ Yes ☐ No

Do you have a gun in your home? ☐ Yes ☐ No

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

SOCIOECONOMICS

Occupation: ______________________ Employer: _____________________

Years of education/highest degree: ________________________

Marital Status: ☐Single ☐Partner/Married ☐Divorced ☐Widowed ☐Other: _________________

Spouse/partner's name: __________________________ Number of children/ages: ________________

Who lives at home with you? ____

WOMEN'S HEALTH HISTORY

Pregnancies: _______ # Vaginal deliveries: ________ # C-section deliveries: ________

Full term births:________ # abortions: ________ # miscarriages: _______

Any complications during pregnancy/delivery ☐ No ☐ Yes If yes, what? ____________________________________

MENSTRUAL CYCLE

Age at start of periods: ___________ Age at end of periods: ___________

☐ Regular ☐ Irregular How many days do cycle last? _____

Menstrual Flow: ☐ Light ☐ Normal ☐ Heavy

When was your last menstrual cycle? _________________________