

Adult Health History

Date:

Name:		Email:	
DOB:	Nickname:	Home Phone:	
Age:	Sex:	Cell Phone:	
Address:		Work Phone:	
City:	State:	Zip:	Emergent Contact Person:
			Emergent Contact Phone:

Past Medical History: *Please check any of the following conditions/problems/diseases that you either now have or have been diagnosed with in the past:*

<input type="checkbox"/> Abuse (physical/mental/ Sexual/Verbal/etc.	<input type="checkbox"/> Bleeding disease	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Serious accident/injury
<input type="checkbox"/> Alcoholism/Drugs	<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/> Genetic diseases	<input type="checkbox"/> Sexual diseases/VD
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Anxiety/Nerves	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma/Allergies	<input type="checkbox"/> Diabetes/sugar	<input type="checkbox"/> Hepatitis (Any)	<input type="checkbox"/> Ulcers/Stomach disease

Others:

Past Surgical History: *List the year you had any of the following:*

<input type="checkbox"/> Appendectomy:	<input type="checkbox"/> Tonsillectomy:
<input type="checkbox"/> Colon/Rectal	<input type="checkbox"/> Blood Transfusion:
<input type="checkbox"/> Cataract:	<input type="checkbox"/> Heart/ Cath:
<input type="checkbox"/> Gallbladder:	<input type="checkbox"/> Hysterectomy:
<input type="checkbox"/> Hernia:	<input type="checkbox"/> Tubal / Vasectomy
<input type="checkbox"/> Others:	
<input type="checkbox"/> Major trauma/injuries	

Current Medications: *List all medications that you take routinely or that have been prescribed for you by a doctor (include vitamins, over-the-counter medications, eye drops, herbal medications, etc.)*

Meds	Dose	How Often	Meds	Dose	How Often

****Attach a medication list or ask for another sheet of paper if medications exceed the space given.****

Allergies: None Antibiotics Foods Inhalants Insects Latex Meds Pollens Skin
 Transfusions X-ray contrast Other

Specify allergy:

Family History:

Blood Relatives	Age if Living	Age at Death	Major Illnesses &/or Cause of Death (Choose from Past Medical History section above)
Mother			
Grandmother			
Grandfather			
Father			
Grandmother			
Grandfather			
Brothers #: _____			
Sisters #: _____			
Children #: _____			

List any other diseases that your blood relatives have:

