1A
1B

Medical Record #: ____________

ADULT PATIENT HEALTH HISTORY

This questionnaire will become a confidential part of your medical record. **If you do not want to answer a question, leave it blank and discuss it privately with your doctor at your visit.**

Today's date: ____/____/____ Appt. date: ____/____/____ Primary care physician? ____________

Name: ______________________________ Date of birth: ____/____/____
Last First Middle

Patient signature: ______________________

WHAT ARE THE MAIN REASONS FOR THIS VISIT?

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________

PHYSICIAN'S COMMENTS

PROOF

MEDICAL HISTORY

Check major, **significant illnesses** which apply to you:

- ☐ Anemia
- ☐ Asthma
- ☐ Arthritis
- ☐ Bleeding/Blood disorder
- ☐ Breast cancer
- ☐ Cancer(s) ____________
- ☐ Cataracts
- ☐ Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Emotion/Mental illness
- ☐ Emphysema
- ☐ Epilepsy/seizures
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart problems
- ☐ Hepatitis/jaundice
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Osteoporosis
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis/TB
- ☐ Ulcers

Others: ______________________

If a doctor has told you that you have a **physical disability** please describe: ______________________

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MEDICATIONS

List all medications you are currently taking which have been ordered by a doctor (including inhalers) and all over the counter drugs, vitamins or herbs. **Please list prescribed medications first:**

Name of Medicine/Dose/Frequency:

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________
6. ____________
7. ____________
8. ____________
9. ____________
10. ____________
11. ____________
12. ____________
13. ____________
14. ____________
15. ____________
16. ____________
17. ____________
18. ____________

CHECK ANY ALLERGIES

☐ Medications List/Describe: ______________________

☐ Food ☐ Animals ☐ Latex ☐ Tape ☐ Pollens ☐ Iodine ☐ Other: ____________

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IHC HC-3000S / 1-07

FACE 1

Medical Record #: ________________

SURGICAL/HOSPITAL

PHYSICIAN'S COMMENTS

List the year of any **Operations/Procedures** you have had (if year unknown ✓):

	Year		Year
Appendix surgery	______	Hip surgery	______
Breast growth removal	______	Hysterectomy	______
Carpal tunnel	______	Knee surgery	______
Cataract surgery	______	Nasal/sinus surgery	______
Cesarean section delivery	______	Plastic surgery	______
Colonoscopy (Looking into Bowel)	______	Polyp removed from intestine	______
D & C	______	Prostate surgery	______
Gall bladder surgery/Laparoscopy	______	Thyroid surgery	______
Gastroscopy (Looking into stomach)	______	Tonsils/Adenoids removed	______
Heart catheterization/surgery	______	Tubal ligation	______
Hernia	______	Vasectomy	______

List any **Trauma/Broken Bones/Serious Accidents:**

____ Year: ______

List any other **Hospitalizations:**

____ Year: ______

What other doctors have you seen? ____

PROOF

FAMILY HISTORY

Are you adopted? ☐ Yes ☐ No

List the cause of death for those who have died prior to age 50 (Do not include accidental deaths)

Father ____________ Mother's Father ____________ Father's Father ____________

Mother ____________ Mother's Mother ____________ Father's Mother ____________

Check any illnesses which have occurred in a **blood related brother (b), sister (s), mother (m), father (f) or grandparent (g):**

	Who		Who
☐ Alcoholism/Substance Abuse	______	☐ Emotional/Mental Illness/Suicide	______
☐ Alzhiemers/Dementia	______	☐ High Blood Pressure	______
☐ Cancer (Breast)	______	☐ Heart Attack prior to age 55	______
☐ Cancer (Colon)	______	☐ Osteoporosis	______
☐ Cancer (Prostate)	______	☐ Stroke	______
☐ Cancer (other) ______	______	☐ Tuberculosis	______
☐ Diabetes	______		

B-1B
B-1A
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SOCIAL HISTORY

Occupation: ________________________ 2 Your gender: ☐ Female ☐ Male

1 Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced If previously married, to whom: ____________

3 List your ethnic origin:

4 ☐ White ☐ Hispanic ☐ American/Alaskan Indian ☐ Black ☐ Asian ☐ Polynesian/Island ☐ Other: ______

Please list number of children and year of birth:

Number of Sons ____ Year of Births ____________ Number of Daughters ____ Year of Births ____________

5 If you have minor children, do they live in your household? ☐ Yes ☐ No

BACK 1; HEAD TO HEAD

2A

2B

Medical Record #: ______________

6 Check if either of these apply to you:
Extensive travel outside the United States (other than vacation)/Military Service ☐ Yes ☐ No

7 What is your **smoking** status? ☐ Never ☐ Past ☐ Current
a. Year quit: __________ b. Number of years smoked: ________
c. Indicate average number of packs used/day: ______________
d. Indicate type: ☐ Smokeless ☐ Cigar ☐ Pipe ☐ Cigarette
e. Would you like help to quit? ☐ Yes ☐ No

8 On average how many alcoholic **drinks** (1 drink = 12 oz. beer, 10 oz. wine cooler, 5 oz. wine, 1.5 oz. liquor) do you consume during one day? ☐ Non-drinker ☐ 1-2 ☐ 3 or more
a. How many do you consume at any one time? ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more
b. Have you ever thought you had a problem with drinking? ☐ Yes ☐ No

9 Do you follow a **special diet**? ☐ Yes ☐ No
☐ Low Salt ☐ Diabetic ☐ Low Fat/Cholesterol
☐ Low Calorie ☐ Vegetarian ☐ Other: ______________

10 How many days per week do you **exercise** for at least 30 minutes? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-7
☐ Walking ☐ Running ☐ Weight lifting
☐ Biking/exercise machine ☐ Swimming ☐ Aerobics
☐ Organized sports ☐ Other: ______________

11 Do you need help from your doctor for an issue related to **drugs?** ☐ Yes ☐ No

12 Do you need help from your doctor for a problem related to physical, verbal, or mental abuse? ☐ Yes ☐ No

13 Are you at risk for AIDS/(HIV)? ☐ Yes ☐ Unknown ☐ No
(Homosexual, Bisexual, Multiple sex partners, Needle drug use other than insulin)

PROOF

LIFE STYLE AND HEALTH RISK

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Women Only:

14 Have you had a Pap Smear within the last 3 years? Year _____ ☐ Yes ☐ Unknown ☐ No
a. Have you had an abnormal Pap Smear? ☐ Yes ☐ No
15 Do you usually do self breast exams? ☐ Yes ☐ No
16 Have you had a professional breast exam within the last 3 years? Year _____ ☐ Yes ☐ No
17 If 40 or above, have you discussed mammography with your doctor? ☐ Yes ☐ No
18 If 50 or above, have you had a mammogram within the last 2 years? Year _____ ☐ Yes ☐ No

Men Only:

19 Have you had a prostate exam? Year _____ ☐ Yes ☐ No

Men and Women Over Age 50 Only:

20 Have you had your stool checked for blood within the last year? ☐ Yes ☐ No
21 Have you had a sigmoidoscopy (intestine exam) within the last 3-5 years? ☐ Yes ☐ No

Men and Women Age 65 or Greater Only:

22 Have you had a flu shot within the last year? Year _____ ☐ Yes ☐ No
23 Have you had a pneumonia shot? Year _____ ☐ Yes ☐ No

Men and Women of All Ages:

24 Have you had a **tetanus/diphtheria** shot within the last 10 years? ☐ Yes ☐ Unknown ☐ No
25 Have you had two **Measles, Mumps, Rubella** shots or the diseases as a child? ☐ Yes ☐ Unknown ☐ No
26 Have you had the following shots: Hepatitis A (Transmitted by food) ☐ Yes ☐ No
Hepatitis B (Transmitted by body secretions) ☐ Yes ☐ No
27 Have you had your cholesterol checked within the last 5 years? ☐ Yes ☐ Unknown ☐ No
Result __________ Year _____
28 Do you wear your seat belt? ☐ Always M Sometimes ☐ Never

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REVIEW OF SYSTEMS:

Check any condition(s) which are **SIGNIFICANT PROBLEMS** to you:

General
- ☐ Recent 10 lb. weight change
- ☐ Fevers (Frequent)
- ☐ Frequent profound fatigue
- ☐ Frequent difficulty sleeping
- ☐ I have had a blood transfusion

Head and Neck
- ☐ Visual changes (Not glasses)
- ☐ Dizziness
- ☐ Double vision
- ☐ Sinus problems
- ☐ Frequent persistent nosebleeds
- ☐ Ear pain
- ☐ Trouble hearing
- ☐ Ringing in the ear
- ☐ Hoarseness
- ☐ Persistent sore throat
- ☐ Mouth sores
- ☐ Swollen glands (Frequent)

Respiratory/Lungs
- ☐ Persistent cough
- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Stop breathing during sleep

Heart/Vascular
- ☐ Chest pain/tightness
- ☐ Irregular rapid heart beat
- ☐ Smothering feeling at night
- ☐ Ankle swelling

Stomach/Bowel
- ☐ Major appetite change
- ☐ Nausea/Vomiting (Frequent)
- ☐ Frequent heart burn/acid in throat (GERD)
- ☐ Abdominal pain
- ☐ Diarrhea (Frequent)
- ☐ Constipation (Frequent)
- ☐ Black/bloody stools
- ☐ Vomiting blood
- ☐ Difficulty swallowing

Kidney/Bladder
- ☐ Kidney/bladder infection
- ☐ Problem with bladder control
- ☐ Difficulty starting urination
- ☐ Frequent urination
- ☐ Increased urgency
- ☐ Urination more than once nightly
- ☐ Burning or painful urination
- ☐ Blood in the urine
- ☐ Difficulty emptying bladder

Reproduction
- ☐ Blood in semen/sperm (men)
- ☐ Inability to have an erection (men)
- ☐ Inability to reach climax
- ☐ Infertility
- ☐ Painful intercourse
- ☐ Decreased sexual desire
- ☐ Sexually Transmitted Diseases

Women:
- ☐ Breast pain/lumps (women)
- ☐ Pelvic pain (women)
- ☐ Vaginal discharge (women)
- ☐ Vaginal dryness (women)
- ☐ Frequent sweats/hot flashes (women)
- ☐ Menstrual problems

  Date of last period: ________
- ☐ Menopause
- ☐ Pregnancy problems
- ☐ Baby weighing 9 lbs. or more

Number of full term births (> 36 wks) _______

Number of premature births (< 36 wks) _______

Number of miscarriages/abortions _______

Number of living children _______

Skeletal
- ☐ Joint pain (Major)
- ☐ Back pain (Major)
- ☐ Neck pain (Major)
- ☐ Weakness in arms/legs
- ☐ Joint swelling/stiffness
- ☐ Deformities of the back/extremities
- ☐ Gout

Neuro
- ☐ Numbness or tingling
- ☐ Severe frequent headaches
- ☐ Abnormal coordination
- ☐ Trouble with speech
- ☐ Forgetfulness/confusion

Skin and Hair Problems
- ☐ Changes in hair/hair loss (Major)
- ☐ Wounds that will not heal
- ☐ Persistent rash
- ☐ Change in moles
- ☐ Major skin problems

Psych/Social
- ☐ Feeling blue/discouraged
- ☐ High anxiety/stress
- ☐ Loss of friends
- ☐ Feeling life has no purpose
- ☐ Feeling others are talking about you
- ☐ Feeling fear
- ☐ Hearing voices
- ☐ Marital or relationship problems
- ☐ Early morning awakenings

PROOF

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B-2A
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BACK 2; HEAD TO HEAD