Gary A. Smith, MD, PLLC *Tracy L. Jones, MS, PA-C*

Name_____ Today's date_____

DOB _____ ❑ M ❑ F

ADULT HEALTH HISTORY

INSTRUCTIONS: Put an (X) in the appropriate box for each question. DO NOT SKIP ANY.

CHECK YOUR HIGHEST EDUCATIONAL LEVEL:

[ ] Grade school [ ] High school [ ] College [ ] Graduate school

WHAT IS YOUR JOB? _____

CHECK THE APPROPRIATE BOX:

[ ] Never married [ ] Living with partner [ ] Married now

[ ] Separated [ ] Divorced [ ] Widowed

CHECK THE APPROPRIATE BOX:

[ ] American Indian or Alaskan Native [ ] Asian or Pacific Islander

[ ] Black, not of Hispanic origin [ ] Hispanic

[ ] White, not of Hispanic origin [ ] Other

THE FOLLOWING QUESTIONS REFER TO YOUR LIFE STYLE:

Yes No

[ ] [ ] Do you eat a balanced diet with plenty of fruits, vegetables, and whole grains and low amounts of fat and cholesterol?

[ ] [ ] Do you diet regularly or frequently to lose weight?

[ ] [ ] Do you get at least 30 minutes of moderate physical activity, such as brisk walking, on most days of the week?

[ ] [ ] Do you chew tobacco or smoke tobacco?
If YES, please answer the following:
How old were you when you started? _____
How much do you smoke/chew? _____ packs per day
Have you tried to quit in the past? [ ] Yes [ ] No
Are you ready to quit now? [ ] Yes [ ] No

[ ] [ ] Do you drink alcohol? **If YES, please answer the following:**
What do you drink? [ ] Beer [ ] Wine [ ] Liquor/mixed drink
How many drinks do you have each day? __ Each week? __

[ ] [ ] Do you have one faithful sexual partner, use safer sex methods each time you have sex (such as condoms), or not have sex?

[ ] [ ] Are you currently using methods to prevent pregnancy?
[ ] [ ] Do you have any sexual concerns or difficulties?
[ ] [ ] Are you under stress much of the time at home or work?
[ ] [ ] Do you feel depressed much of the time?
[ ] [ ] Are you exposed to hazards or dangers at work?
[ ] [ ] When you have arguments with others, is anyone ever violent?
[ ] [ ] **If you have children:** Parenting can be hard; do you ever hit or feel like hitting your kids?
[ ] [ ] Are you satisfied with your life overall?

How long ago was your last tetanus booster? _____
How long ago was your last blood cholesterol test? _____

FOR WOMEN:

How long ago was your last Pap smear and pelvic exam? _____

How long ago was your last mammogram? _____

HAVE YOU EVER HAD:

Yes No

[ ] [ ] Anemia (low blood count)
[ ] [ ] Arthritis
[ ] [ ] Asthma
[ ] [ ] Breast disease (females)
[ ] [ ] Bronchitis or pneumonia
[ ] [ ] Cancer
[ ] [ ] Dental problems
[ ] [ ] Diabetes mellitus
[ ] [ ] Drinking or drug problem
[ ] [ ] Emphysema
[ ] [ ] Epilepsy/seizure disorder
[ ] [ ] German measles
[ ] [ ] Glaucoma or cataracts
[ ] [ ] Gout
[ ] [ ] Hayfever or seasonal allergies
[ ] [ ] Hearing problems
[ ] [ ] Heart disease
[ ] [ ] Hemorrhoids
[ ] [ ] High blood pressure
[ ] [ ] High cholesterol/triglycerides
[ ] [ ] Kidney disease (chronic)
[ ] [ ] Liver disease
[ ] [ ] Measles
[ ] [ ] Mental or emotional problems
[ ] [ ] Mumps
[ ] [ ] Polyps or growth in bowels
[ ] [ ] Rheumatic fever
[ ] [ ] Stomach or duodenal ulcers
[ ] [ ] Stroke
[ ] [ ] Thyroid disease
[ ] [ ] Tuberculosis (TB)
[ ] [ ] Venereal/sexually transmitted disease
[ ] [ ] Vision problems (NOT glasses)
[ ] [ ] Weight problem
[ ] [ ] Other (please list below)

_____

LIST ANY OPERATIONS THAT YOU'VE HAD (ALSO LIST YEAR)

_____

_____

CONTINUE ON BACK

LIST NON-PRESCRIPTION DRUGS YOU REGULARLY TAKE:	LIST ANY PRESCRIPTION DRUGS THAT YOU TAKE:	LIST ANY DRUGS THAT YOU ARE ALLERGIC TO:

HAVE ANY OF YOUR BLOOD RELATIVES EVER HAD:

Yes	No		Yes	No		Yes	No	
[ ]	[ ]	Anemia	[ ]	[ ]	Drinking or drug problem	[ ]	[ ]	Obesity
[ ]	[ ]	Arthritis	[ ]	[ ]	Epilepsy/seizures	[ ]	[ ]	Stroke
[ ]	[ ]	Birth defect	[ ]	[ ]	Glaucoma	[ ]	[ ]	Suicide or attempted suicide
[ ]	[ ]	Bleeding tendency	[ ]	[ ]	Heart attack or heart disease	[ ]	[ ]	Tuberculosis
[ ]	[ ]	Cancer	[ ]	[ ]	High blood pressure	[ ]	[ ]	Other (please list below)
[ ]	[ ]	Deafness	[ ]	[ ]	Mental or emotional problems			
[ ]	[ ]	Diabetes mellitus	[ ]	[ ]	Nerve or muscle disease			_____

DO YOU OR YOUR FAMILY HAVE ANY CONCERNS OR PROBLEMS WITH:

Yes	No		Yes	No		Yes	No	
[ ]	[ ]	Other family members	[ ]	[ ]	Transportation	[ ]	[ ]	Recent death of spouse, friend, or family member
[ ]	[ ]	Friends	[ ]	[ ]	Recent loss of job or retirement			
[ ]	[ ]	Housing or living arrangements	[ ]	[ ]	Mental or emotional difficulties	[ ]	[ ]	Neighborhood violence
[ ]	[ ]	Finances	[ ]	[ ]	Serious illness or disability	[ ]	[ ]	Family violence
[ ]	[ ]	Education	[ ]	[ ]	Alcohol or drug use	[ ]	[ ]	Other (please list below)
[ ]	[ ]	Job or employment	[ ]	[ ]	Recent break-up, separation, or divorce			
[ ]	[ ]	Legal						_____

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR ALL FAMILY MEMBERS (WHERE POSSIBLE):

Name(s)	Gender	Date of Birth/Age	Marital Status	Living at home?
Spouse or partner:				
Children:				
Others living in household:				

PLEASE LIST ANY ADDITIONAL PROBLEMS, CONCERNS, OR INFORMATION ABOUT YOU OR YOUR FAMILY THAT YOU WOULD LIKE THE HEALTH CARE PROVIDER TO KNOW ABOUT:

_____

_____

SIGNATURE (PATIENT) _____