ADULT HEALTH ASSESSMENT SHEET

In order to help us deliver quality care, we would appreciate your responses to the personal history questions below. Please be assured that all responses are kept confidential. You should feel free to discuss any questions you have concerning these items with the doctor or nurse.

DO YOU HAVE ANY PARTICULAR HEALTH CONCERNS AT THIS TIME YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR OR NURSE?

________________________________________________________________________

ALLERGIES

Do you have any allergies to medications, foods, or other substances? If yes, please list along with the reaction you have.

________________________________________________________________________

MEDICATIONS

Please list all MEDICATIONS including the DOSES that you are currently taking: (Prescription, Over the Counter, Vitamins, Herbs)

________________________________________________________________________

________________________________________________________________________

Please check if you have any of these diseases or if you have any of these symptoms that reoccur frequently:

☐ High Blood Pressure
☐ Diabetes
☐ Cancer
☐ Heart Disease
☐ Chest Pain/Tightness
☐ Heart Murmur
☐ Shortness of Breath
☐ Swollen Ankles
☐ Palpitations/Heart Pounding
☐ Lightheadedness
☐ Rheumatic Fever
☐ Tuberculosis
☐ Asthma
☐ Bronchitis
☐ Pneumonia
☐ Persistent Cough
☐ Hay Fever

☐ Sinus Problems
☐ Abdominal Discomfort
☐ Indigestion
☐ Nausea
☐ Vomiting
☐ Constipation
☐ Diarrhea
☐ Change in Bowel Habits
☐ Blood in Stool
☐ Hemorrhoids
☐ Ulcers
☐ Unexplained Weight Loss/Gain
☐ Colitis
☐ Gall Bladder Disease
☐ Pancreatitis
☐ Liver Disease
☐ Hepatitis/Yellow Jaundice
☐ Thyroid Disease
☐ Head or Neck Radiation
☐ Headache
☐ Migraines
☐ Kidney Disease
☐ Kidney Stones
☐ Difficulty Urinating
☐ Frequent Urination
☐ Arthritis
☐ Low Back Problems
☐ Bone/Joint Problem
☐ Blood Transfusions
☐ Anemia
☐ Blood Disorders
☐ Lumps/Moles
☐ Skin Diseases
☐ Sexually Transmitted Diseases
☐ HIV/AIDS
☐ Anxiety
☐ Depression
☐ Sleeping Problems
☐ Alcohol Abuse
☐ Drug Abuse
☐ Gout
☐ Seizures
☐ Visual Problems
☐ Hearing Problems
☐ Measles
☐ Chicken Pox
☐ Mumps

PLEASE TURN AND COMPLETE OTHER SIDE.
PATIENT NAME: 

Please list all HOSPITALIZATIONS and OPERATIONS you have had and give the approximate DATE of each:

_________________________________________       __________________________
_________________________________________       __________________________
_________________________________________       __________________________

For WOMEN Only:

Date of last menstrual cycle _________       Age of Onset of Periods?__________
Do you do self breast exams monthly? No □ Yes □
Any history of abnormal Pap Smears? No □ Yes □ If yes, explain ________________________
Any prolonged or abnormal bleeding? No □ Yes □
Any pelvic pain? No □ Yes □
Any abnormal discharge? No □ Yes □
Do you take a calcium supplement? No □ Yes □
Number of Pregnancies___________       Number of miscarriages or abortions ______

For MEN only:

Do you do self testicular exams? No □ Yes □
Have you had a prostate exam? No □ Yes □
Have you had a PSA (blood work to check your prostate)? No □ Yes □
Have you ever had an abnormal prostate exam or PSA? No □ Yes □ If yes, explain ______________________

Do you have any problems with urination? No □ Yes □ If yes, explain ______________________

SEXUAL HISTORY

Are you sexually active? No □ Yes □
Would you characterize your sexual preferences as:
□ Heterosexual □ Homosexual □ Bisexual
Do you have multiple sexual partners? No □ Yes □
Do you use condoms? No □ Yes □
What method of contraception do you use? ______________________

FAMILY HISTORY

Is your mother alive? No □ Yes □ If not, age at death and cause of death ______________________
Is your Father alive? No □ Yes □ If not, age at death and cause of death ______________________
Number of siblings: Sisters ________ Brothers ________
Do any of your siblings have a serious illness?__________ If yes, explain ______________________
ADULT HEALTH ASSESSMENT SHEET

FAMILY HISTORY

Has anyone in your IMMEDIATE family had any of the following illnesses:

<table>
<thead>
<tr>
<th>Illness</th>
<th>Which Family Member</th>
<th>Age When Diagnosed</th>
<th>Illness</th>
<th>Which Family Member</th>
<th>Age When Diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer (describe type)</td>
<td></td>
<td></td>
<td>Bleeding Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strokes</td>
<td></td>
<td></td>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Disease</td>
<td></td>
<td></td>
<td>Genetic Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glaucoma</td>
<td></td>
<td></td>
<td>Arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug/Alcohol</td>
<td></td>
<td></td>
<td>Kidney Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addiction</td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SOCIAL HISTORY

How many people live with you now? ________________________________________________________________

Present occupation ____________________________________________________________________________

Previous occupations __________________________________________________________________________

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? ______________________

______________________________________________________________________________________________

Have you ever been exposed to any environmental hazards such as radiation, toxic waste, or lead paint? ________

______________________________________________________________________________________________

PERSONAL HABITS

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you wear your seat belt?</td>
<td>No □</td>
<td>Yes □</td>
</tr>
<tr>
<td>Do you wear a bike helmet?</td>
<td>No □</td>
<td>Yes □</td>
</tr>
<tr>
<td>Do you use tobacco products?</td>
<td>No □</td>
<td>Yes □</td>
</tr>
<tr>
<td>Do you drink alcohol?</td>
<td>No □</td>
<td>Yes □</td>
</tr>
<tr>
<td>Coffee?</td>
<td>No □</td>
<td>Yes □</td>
</tr>
<tr>
<td>Tea?</td>
<td>No □</td>
<td>Yes □</td>
</tr>
<tr>
<td>Do you follow a particular diet?</td>
<td>No □</td>
<td>Yes □</td>
</tr>
<tr>
<td>Do you exercise regularly?</td>
<td>No □</td>
<td>Yes □</td>
</tr>
<tr>
<td>Any recent travel outside U.S.?</td>
<td>No □</td>
<td>Yes □</td>
</tr>
<tr>
<td>Do you have a gun in your house?</td>
<td>No □</td>
<td>Yes □</td>
</tr>
<tr>
<td>Do you use drugs? (cocaine, crack, marijuana, amphetamines, etc)</td>
<td>No □</td>
<td>Yes □</td>
</tr>
<tr>
<td>Do you have smoke detectors in your home?</td>
<td>No □</td>
<td>Yes □</td>
</tr>
</tbody>
</table>

Patient Name: ______________________________

DOB: _____________________________________

PLEASE TURN AND COMPLETE OTHER SIDE.
Patient Name: ___________________________________________________ DOB: _________________

**IMMUNIZATIONS**

Have you had any of the following **IMMUNIZATIONS**:

- **Hepatitis B?**
  - No □ Yes □ Approximate Date _______________

- **Tetanus?**
  - No □ Yes □ Approximate Date _______________

- **Flu Shot?**
  - No □ Yes □ Approximate Date _______________

- **Pneumovax?**
  - No □ Yes □ Approximate Date _______________

- **Measles?**
  - No □ Yes □ Approximate Date _______________

- **Mumps?**
  - No □ Yes □ Approximate Date _______________

- **Rubella?**
  - No □ Yes □ Approximate Date _______________

**HEALTH MAINTENANCE**

When was your **LAST**: (give approximate date)

- **Pap Smear?** _______________  **Cholesterol Check?** _______________
- **Breast Exam?** _______________  **Stool Check for Blood?** _______________
- **Mammogram?** _______________  **Prostate Exam?** _______________
- **Complete Physical?** _______________  **Sigmoid Exam?** _______________

Do you have a “living will” or advance directive?  No □ Yes □
Are you an organ donor?  No □ Yes □

**Completed By:** _____________________________________________ Date: _______________

**Reviewed By:** _____________________________________________ Date: _______________