Adult History Information

Name: ________________________________ Today's Date: __________________ Date of Birth: ___________________

Primary care physician: __________________ Referred by: ____________________ Pharmacy Phone: ________________

Allergies:

- ☐ Medications: ____
- ☐ Food: ____
- ☐ Contactants: ____
- ☐ Environmental: ____

Family History: Please check all of the conditions someone in your immediate family (mother, father, brother, sister) has been diagnosed with (not including yourself).

- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes Mellitus
- ☐ Gout
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Seizure
- ☐ Thyroid Disease

Past Medical History: Please check all that apply to you.

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer: ___________________
- ☐ Duodenal Ulcer
- ☐ Concussion
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ CVA
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Eating Disorder
- ☐ Hiatal Hernia
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Infectious Mononucleosis
- ☐ Kidney Problems
- ☐ Pneumonia
- ☐ Seizure Disorder
- ☐ Sexually Transmitted Disease
- ☐ Thrombophlebitis
- ☐ Thyroid Disease
- ☐ Urinary Tract Problem

Surgeries: Please check all that apply to you:

- ☐ Appendectomy, date ___________
- ☐ Cholecystectomy, date ___________
- ☐ Coronary Artery Bypass, date ___________
- ☐ Vasectomy, date ___________
- ☐ Hysterectomy, date ___________
- ☐ Inguinal Hernia, date __________
- ☐ Laminectomy, date ___________
- ☐ Other: ____
- ☐ Splemectomy, date _____________
- ☐ Tonsillectomy, date ___________
- ☐ Umbilical Hernia, date __________

Social History: Please check all that apply for you.

Smoking ☐ Never ☐ Quit, when __________________ ☐ Yes, how much ______________

Do you exercise regularly? ☐ No ☐ Yes What? _________________ How often? ____________________

Current Medications (with dosage)**:**

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Review of Systems:

Have you recently experienced any of the following: (please check all that apply)

General:
- ☐ Chills
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight gain > 10 lbs
- ☐ Weight loss < 10 lbs

Skin:
- ☐ Bruising
- ☐ Pallor
- ☐ Rash
- ☐ Color Change

HEENT:
- ☐ Headache
- ☐ Head Injury
- ☐ Seasonal Allergies

Respiratory:
- ☐ Cough
- ☐ Low Exercise Tolerance
- ☐ Wheezing
- ☐ Difficulty Breathing

Cardiovascular:
- ☐ Chest Pain
- ☐ Fainting
- ☐ Blacking Out
- ☐ Hypertension
- ☐ Irregular Heart Beat
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Extremities

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Male Genitourinary
- ☐ Blood in Urine
- ☐ Change in Bladder Habits
- ☐ Testicular Pain
- ☐ Testicular Mass
- ☐ Change in Urinary Stream

Musculoskeletal:
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Muscle Pain
- ☐ Muscle Weakness

Neurological:
- ☐ Decreased Memory
- ☐ Dizziness
- ☐ Fainting
- ☐ Loss of Consciousness
- ☐ Seizures

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Mood Changes

Endocrine:
- ☐ Cold Intolerance
- ☐ Excessive Thirst
- ☐ Thyroid Problems

Hematology:
- ☐ Anemia
- ☐ Easy Bruising
- ☐ Prolonged Bleeding