Great Lakes
Medical Associates

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# ADULT HEALTH HISTORY FORM

Date form Completed: _____

Name_____ DOB_____

**How would you rate your general health?** Excellent Good Fair Poor

**Main reason for today's visit?** _____

**REVIEW OF SYMPTOMS:** Please check any current symptoms you have:

*General*
___ Recent fevers/sweats
___ Unexplained weight loss/gain
___ Unexplained fatigue/weakness

*Eyes*
___ Vision Problems
___ Eye Pain

*Ears/Nose/Throat*
___ Earache
___ Ear Drainage
___ Hearing Loss
___ Allergies/Hay Fever
___ Sinus Problems
___ Nosebleeds

*Heart/Cardivascular*
___ Chest Pain/Discomfort
___ Heart Murmur
___ Irregular/rapid heartbeat/palpitations
___ Decreased exercise intolerance

*Lungs/Respiratory*
___ Cough/Wheeze
___ Pain with Breathing
___ Pneumonia
___ Asthma
___ Shortness of Breath

*Gastrointestinal*
___ Heartburn/Reflux
___ Change in bowel habits
___ Vomiting/Nausea
___ Abdominal Pain

*Endocrinology*
___ Heat/Cold intolerance
___ Increased thirst/appetite

*Skin*
___ Rash
___ Unusual/Changing Moles

*Neurological*
___ Headaches
___ Memory Loss
___ Seizures/Epilepsy
___ Fainting
___ Dizziness

*Blood/Lymph*
___ Anemia
___ Unexplained Lumps
___ Easy bruising/bleeding

*Psychiatric/Emotional*
___ Anxiety/Stress
___ Depression
___ Sleep Problems

*Genitourinary*
___ Blood in Urine
___ Painful Urination
___ Leaking Urine
___ Discharge: Penis/Vagina
___ Concern with sexual function

*Musculoskeletal*
___ Muscle/Joint Pain
___ Back Pain
___ Weakness
___ Swollen Joints

**IMMUNIZATIONS:**
Hepatitis A_____ Hepatitis B_____ Influenza (flu shot)___ MMR ___ Pneumovax (pneumonia)_____
Meningitis___ Tetanus (Td)___ Varicella (chicken pox) ___ Tdap (tetanus & pertussis)_____

**CURRENT MEDICATIONS:**

Please list all prescription and over the counter medications you are taking

| Medication | Dose | Reason | How Long |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**PREFERRED PHARMACY:** _____

**ALLERGIES:**

Medications: _____ Foods: _____

Other: _____

**HEALTH MAINTENANCE:** (Date of Most recent record)

Labs _____ Abnormal? Yes No
Colonoscopy _____ Abnormal? Yes No
Bone Density _____ Abnormal? Yes No
Women: Mammogram _____ Abnormal? Yes No
Women: Pap Smear _____ Abnormal? Yes No
Men: PSA ___ Abnormal? Yes No

**WOMEN'S HEALTH HISTORY:**

# pregnancies _____ # deliveries_____ # abortions_____ # miscarriages_____
Age at start of periods _____ Age at end of periods _____

**SURGICAL HISTORY:**

| Surgery | Year of surgery |
|---|---|
| | |
| | |
| | |
| | |
| | |

**FAMILY HISTORY:** Please indicate which, if any, family members have the current health conditions:

Alcoholism/Drug Abuse _____ High Blood Pressure: _____
Cancer (specific type): _____ Stroke: _____
Heart Attack: _____ Bleeding/Clotting Disorder: _____
Depression/Anxiety: _____ Asthma/COPD: _____
Diabetes: _____ Genetic Disorder: _____
Kidney Disease:_____ Other: _____
High Cholesterol: _____

**SOCIAL HISTORY**

Occupation: _____
Marital Status: _____ Number of Children/Ages: _____

PLEASE ANSWER THE FOLLOWING

| | | | |
|---|---|---|---|
| Do you smoke? | Yes | No | # packs per day _____ # of years _____ |
| Do you chew tobacco? | Yes | No | |
| Do you drink alcohol? | Yes | No | |
| Do you use recreational drugs | Yes | No | |
| History of Emotional Abuse? | Yes | No | |
| History of Physical Abuse? | Yes | No | |
| History of Sexual Abuse? | Yes | No | |
| Do you feel safe at home? | Yes | No | |

SEXUAL ACTIVITY:

Sexually active: Yes Not currently

Have you been with more than one sexual partner in the last 6 months? Yes No

Have you ever had a sexually transmitted disease? Yes No

Are you interested in being screened for any sexually transmitted diseases? Yes No

ADVANCE DIRECTIVE:

Do you have an advance directive? Yes No (If yes, please provide our office with a copy)

Would you like an advance directive form? Yes No

Do you have questions regarding advance directives? Yes No

**Patient Signature:** _____ **Date:** _____

**Physician Signature:** _____ **Date:**_____