*835 7th St Suite 5*
*Clermont ,FL 34711*
*Phone: 352-404-8961 Fax: 352-404-8996*

*Name* ____________________________ *Date*__________________

***Adult Health History Form .***

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. **Thank You.**

Date of Birth: ____________ How would you rate your general health? □ Excellent □ Good □ Fair □ Poor

**Main reason for today's visit:** ____________________________________________________________________________

**Other concerns:** ________________________________________________________________________________

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

____ Unexplained weight loss/gain ____ Recent fevers/sweats ____ Unexplained fatigue/weakness ____ Recent chills/cold sweats

*Cardiology*

____ Chest pains/discomfort ____ Palpitations ____ Decreased exercise tolerance

*Dermatology*

____ Rash ____ New or change in mole

*Endocrinology*

____ Cold/heat intolerance ____ Increase thirst/appetite

*ENT*

____ Change in hearing ____ Congestion ____ Sinus pain ____ Sore throat

*Hematology/Lymph*

____ Unexplained lumps ____ Easy bruising/bleeding

*Genitourinary*

____ Painful/bloody urination ____ Leaking urine ____ Nighttime urination ____ Discharge: penis or vagina ____ Concern with sexual functions

*Gastroenterology*

____ Heartburn/reflux ____ Bloody stools ____ Change in bowel movement ____ Nausea/vomiting/diarrhea ____ Pain in abdomen

*Musculoskeletal*

____ Muscle/joint pain ____ Recent back pain ____ Weakness ____ Swollen joints

*Neurology*

____ Memory loss ____ Headaches ____ Fainting ____ Numbness/tingling in hands/feet ____ Loss of balance

*Ophthalmology*
____ Change in vision ____ Eye pain
*Psychology*
____ Anxiety/stress ____ Sleep problems
*Respiratory*
____ Cough/wheeze ____ Coughing blood ____ Short of breath with exertion ____ Pain with breathing
*Women*
____ No periods ____ Heavy periods ____ Painful periods ____ Irregular periods ____ Unusual vaginal bleeding
Date of last period: _____________ Menopause at age: _____________

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? □ Yes □ No

**MEDICATIONS:** Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication/Vitamin/Supplement; Dose/Strength (e.g., mg/pill) ; How many times per day:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**ALLERGIES:** Do you have allergies or reactions to medications? Yes or No (Please Circle one)

Reaction:______________________________________________________________________
**Foods?** Reaction: ____________________________________________________________________

**IMMUNIZATIONS:** Date of most recent record. __________________________(Please check all that apply)

Hepatitis A ______ Hepatitis B ______ Influenza (flu shot) ______ MMR ______ Meningitis ___
Tetanus (Td) ______ Varicella (chicken pox) shot or illness ______
(pneumonia) ______ Tdap (tetanus & pertussis) ______

**HEALTH MAINTENANCE:** Date of most recent record. (Please put date near maintenance below)

Cholesterol _________ Colonoscopy ___________ Bone Density Scan __________

*Women*: Mammogram ______ *Men:* PSA (prostate) ______

**Past MEDICAL HISTORY**
**List any major medical illness previously diagnosed:**

**Heart (Hypertension ,High Cholesterol) :** ____________________________________________

**Dermatology/Skin:**______________________________________________________________________

**Endocrinology(Diabetes, Thyroid) :** ____________________________________________________

**ENT(Asthma):**___________________________________________________________________________

**Hematology(Blood):**______________________________________________________________________

**GU/Urinary:** __________________________________________________________________________

**Gastro/GI (gastritis, ulcerative colitis, GERD, diverticulitis):**___________________________________________________________________________

**Musculoskeletal(arthritis):**_________________________________________________________________

**Nervous System (depression, anxiety)**
____________________________________________________________________

**Other:**_____________________________________________________________________________

**SURGICAL HISTORY:**
Year of Surgery
Reason for Surgery
1________________________________________________________________________________
2________________________________________________________________________________
3________________________________________________________________________________
4________________________________________________________________________________

**FAMILY HISTORY:** Please indicate family members (parent, sibling, grandparent) with any of the following conditions:
Alcoholism, Cancer, Specific Type of Heart disease, Hypertension, Depression/suicide, Genetic disorders , Diabetes, Kidney disease , Liver disease, Glaucoma, Thyroid Disease ,COPD, Asthma, Allergy

**Mother**_______________________________________________________________

**Father**_______________________________________________________________

**Sister**_________________________________________________________________________

**Brother**_______________________________________________________________________

**Maternal Grandmother**__________________________________________________________

**Maternal Grandfather**_______________________________________________________________

**Paternal Grandmother**_______________________________________________________________

**Paternal Grandfather** _______________________________________________________________

**Other**_____________________________________________________________________________

**SOCIAL HISTORY: Tobacco Use:** Cigarettes □ Never. Quit Date ________________ □ Current Smoker: packs/day _____ # of yrs _____

Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew

Are you interested in quitting? □ Yes □ No

**Caffeine Intake:** □ None □ Coffee/tea/soda _____cups/day

**Weight:** Are you satisfied with your weight? □ Yes □ No

**Diet:** How do you rate your diet? □ Good □ Fair □ Poor. Do you eat or drink four servings of

dairy or soy daily or take calcium supplements? □ Yes □ No

**Exercise:** Do you exercise regularly?□ Yes □ No

What kind of exercise?______________________________ How long (minutes)__________

How often?_____________ If you do not exercise, why?__________________________

**SOCIOECONOMICS:**
Occupation:_______________________________________
Employer:_________________________________________
Martial Status: □ Single □ Partner/Married □ Divorced □ Widowed
Number of children/ages:_____________________________

**WOMENS HEALTH HISTORY**

# Pregnancies: __________ # Deliveries: __________ # Abortions: ___________ # Miscarriages:

___________ Age at start of periods: ______ Age at end of periods: _____

**Alcohol Use**
Do you drink alcohol? □ Yes □ No # drinks/week _____

Is your alcohol use a concern for you or others? □ Yes □ No

**Drug Use**

Do you use any recreational drugs? □ Yes □ No

Have you ever used needles to inject drugs?(Please circle) Yes or No

**Sexual Activity**
Sexually active: □ Yes □ No □ Not currently

Current sex partner(s) is/are: □ male □ female

Birth control method: ___________ □ None needed

Have you ever had any sexually transmitted diseases (STDs)? □ Yes □ No

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