HEALTH HISTORY-ADULT

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Date: ____________________

Name: *(Surname)*__________________ (*First name*)______________________
Gender (*circle*)*: M / F*
Date of Birth:
(*Month*)_____________(*Day*)_____________(*Year*)_____________________________

Birthplace***:*** *(Country)*________________ *(Province/State)*__________________

____

_______________________________________*(Postal Code)*______________________
Phone Number*:*
Home: (__________)___________________ Work: (________)__________________
Cell: (_________)______________________Email: _____________________________
Which of the above do you give permission for our office to contact you at? (circle above)

Emergency Contact:
*Name: (Surname)*_____________________*(First Name)*______________
*Telephone: (_________)________________ (Relation to Patient)*_______

Marital Status*:(circle)*
Married/Single/Widowed/ Divorced/ Separated/Common-law/Same Sex
Live With*: (circle) Spouse / Partner / Parents / Children / Friends / Alone*
Children: Name:______________________Age:_________________Gender: M/ F
N*ame:*_______________________*Age:*_________________*Gender: M/ F*
*Name:*_______________________*Age:*_________________*Gender: M/F*
*Name:*_______________________*Age:*_________________*Gender: M/F*
Dependents*:*
*Name(s):*____
*Relationship to the Patient:*____
Ethnicity*:*____
Occupation*:*____
Medical Doctor*:*
*(Name)*____
*(Address)*____
*(Telephone)*____
*(Fax)*____
*Other Health Care Professionals:*____

____
____
____
____
____
____

Reasons for Seeking Care *(please list in order of importance to you):*

1. ____
2. ____
3. ____
4. ____
5. ____

Childhood Illnesses (circle):
*Measles / Mumps / Rubella / Chickenpox / Whooping Cough / Strep Throat / Rheumatic Fever / Scarlet Fever / Poliomyelitis / Other:*____________________

Accident(s) / Injuries (circle):
Automobile accident / Fracure / Break / Penetrating Wounds / Head Injury / Burns /
Other: (Describe / Dates):____________________________
____
____

History of Serious or Chronic Illness (circle):
Diabetes / Hypertension / Heart Disease / Sickle-Cell Anemia / Cancer / Seizure Disorder
Other: (Describe / Dates):____________________________
____
____

Hospitalization(s): (Cause / Name of Hospital / Treatment Received / Date and Duration of Hospitalization/ Name of Physician):
____
____
____
____

Operation(s): (Type of Surgery / Date of Surgery / Name of Surgeon / Name of Hostpital / Recovery):____________________________
____
____
____

Current Medications:

Drug Name	Dose	Frequency	Date /Onset	Discontinued

Allergies: (Medication / Food / Environmental / Plant / Animal/Insect/ Vaccine reaction)

____

____

Immunizations:

Immunization	Date
Measles – Mumps – Rubella	
Polio	
Diptheria – Pertussis – Tetanus	
Hepatitis B	
Hepatitis A	
Haemophilus Influenzae Type B	
Pneumococcal Vaccine	
Varicella	
Other	

Last Examination Dates:

Examination	Date
Physical	
Dental	
Vision	
Hearing	
Mammogram	
Electrocardiogram	
Bone Density	
Colonoscopy	
Fecal Occult Blood	
Other	

Family Health History:

Do any of the following health conditions affect your family members?

Condition	Presence in Family	Relative affected
Heart Disease		
High Blood Pressure		
Stroke		
Diabetes		
Blood Disorder		

Sudden Infant Death		
Birth Defects		
Learning Disabilities		
Mental Retardation		
Cystic Fibrosis		
Sickle Cell Anemia		
Cancer		
Tuberculosis		
Arthritis		
Allergies		
Obesity		
Alcoholism		
Mental Illness		
Seizure Disorder		
Kidney Disease		
Other		

Current Weight/Height:(Gain/Loss over period of time – cause)__________
____
____

Are you experiencing any of the following symptoms? (circle)
Fatigue / Weakness / Fever / Chills / Sweating / Night Sweats

If you are currently experiencing or have frequently experienced any of the following, place a checkmark in the corresponding box:
Y = Currently experiencing N= Never experienced P = Experienced *frequently* in Past

Skin/Hair/Nails	**Assessment**	**Comments**
Skin Disease	Y N P	______________________
Skin Rashes / Lesions	Y N P	______________________
Skin Pigment Change	Y N P	______________________
Change in Mole	Y N P	______________________
Excessive Itching	Y N P	______________________
Excessive Bruising	Y N P	______________________
Excessive Dryness	Y N P	______________________
Excessively Moist	Y N P	______________________
Excessive Hair Loss	Y N P	______________________
Excessive Hair Growth	Y N P	______________________
Hair Texture Change	Y N P	______________________
Nail Changes	Y N P	______________________

Head	**Assessment**	**Comments**

Head Injury	Y	N	P	____________
Vertigo / Dizziness	Y	N	P	____________
Headache / Migraine	Y	N	P	____________

Nose & Sinuses	**Assessment**			**Comments**
Nosebleeds	Y	N	P	____________
Sinusitis	Y	N	P	____________
Nasal Congestion	Y	N	P	____________
Nasal Polyps	Y	N	P	____________
Frequent Colds	Y	N	P	____________
Sense of Smell Change	Y	N	P	____________

Eyes & Ears	**Assessment**			**Comments**
Vision Changes	Y	N	P	____________
Corrective Lenses	Y	N	P	____________
Eye Disease	Y	N	P	____________
Eye Pain	Y	N	P	____________
Eye Discharge	Y	N	P	____________
Eye Red/ Swelling	Y	N	P	____________
Hearing Loss	Y	N	P	____________
Ear Pain / Infection	Y	N	P	____________
Tinnitus (Ear Ringing)	Y	N	P	____________

Mouth & Throat	**Assessment**			**Comments**
Mouth or Tongue Pain / Lesion	Y	N	P	____________
Frequent Sore Throat	Y	N	P	____________
Gum Disease	Y	N	P	____________
Toothache	Y	N	P	____________
Swallowing Difficulty	Y	N	P	____________
Hoarseness	Y	N	P	____________
Tonsillectomy	Y	N	P	____________
Taste Sense Altered	Y	N	P	____________
Neck Pain	Y	N	P	____________
Neck Restricted Motion	Y	N	P	____________
Neck Swelling	Y	N	P	____________
Lymph Nodes Enlarged	Y	N	P	____________

Chest	**Assessment**			**Comments**
Lung Disease	Y	N	P	____________
Bronchitis	Y	N	P	____________
Pneumonia	Y	N	P	____________
Emphysema	Y	N	P	____________
Shortness of Breath	Y	N	P	____________
Pain on Breathing	Y	N	P	____________
Tuberculosis	Y	N	P	____________

	Assessment			Comments
Cough	Y	N	P	______
Chest Pain	Y	N	P	______
Heart Palpitation	Y	N	P	______
Cardiovascular Disease	Y	N	P	______
Hypertension	Y	N	P	______
High Cholesterol	Y	N	P	______
Breast Pain	Y	N	P	______
Nipple Discharge	Y	N	P	______
Breast Lump	Y	N	P	______

Gastrointestinal	**Assessment**			**Comments**
Appetite Change	Y	N	P	______
Food Intolerance	Y	N	P	______
Heartburn	Y	N	P	______
Indigestion	Y	N	P	______
Abdominal Pain	Y	N	P	______
Nausea / Vomiting	Y	N	P	______
Gastrointestinal Disease	Y	N	P	______
Constipation	Y	N	P	______
Diarrhea	Y	N	P	______
Rectal Condition	Y	N	P	______

Urinary Tract	**Assessment**			**Comments**
Pain on Urination	Y	N	P	______
Increased Frequency	Y	N	P	______
Frequency at Night	Y	N	P	______
Incontinence	Y	N	P	______
Bladder Infections	Y	N	P	______
Kidney Infections	Y	N	P	______
Kidney Stones	Y	N	P	______
Blood in Urine	Y	N	P	______
Urgency	Y	N	P	______
Hesitancy	Y	N	P	______

Musculoskeletal	**Assessment**			**Comments**
Muscle Pain	Y	N	P	______
Joint Pain	Y	N	P	______
Osteoporosis	Y	N	P	______
Osteoarthritis	Y	N	P	______
Rheumatoid Arthritis	Y	N	P	______

Peripheral Vascular	**Assessment**			**Comments**
Varicose Veins	Y	N	P	______
Swelling of Hands/Feet	Y	N	P	______
Numbness / Tingling	Y	N	P	______
Discolored Hands/Feet	Y	N	P	______

Deep Leg Pain	Y	N	P	______
Cold Extremities	Y	N	P	______
Leg Cramps	Y	N	P	______

Neurological	**Assessment**			**Comments**
Memory loss	Y	N	P	______
Fainting	Y	N	P	______
Seizures/Convulsions	Y	N	P	______
Paralysis	Y	N	P	______
Muscle Weakness	Y	N	P	______
Numbness/Tingling	Y	N	P	______
Involuntary Movement	Y	N	P	______
Tremor	Y	N	P	______
Loss of Balance	Y	N	P	______

Endocrine	**Assessment**			**Comments**
Heat or cold intolerant	Y	N	P	______
Thyroid Disorder	Y	N	P	______
Hormone Therapy	Y	N	P	______
Excessive Thirst	Y	N	P	______
Excessive Urination	Y	N	P	______
Excessive Sweating	Y	N	P	______
Diabetes	Y	N	P	______
Hypoglycemia	Y	N	P	______

Immune/Blood	**Assessment**			**Comments**
Anemia	Y	N	P	______
Easy to Bleed/Bruise	Y	N	P	______
Past blood transfusion	Y	N	P	______
Lymph node swelling	Y	N	P	______
Autoimmune Disease	Y	N	P	______
Infectious Disease	Y	N	P	______

Mental /Emotional	**Assessment**			**Comments**
Depression	Y	N	P	______
Anxiety	Y	N	P	______
Mood Swings	Y	N	P	______
Bipolar Disorder	Y	N	P	______
Tension /Stress	Y	N	P	______
Phobias	Y	N	P	______
Insomnia	Y	N	P	______
Eating Disorder	Y	N	P	______
Other				______

Describe the Emotional Climate of your Home:______________________

____

____

Female Reproductive	Assessment			Comments
Regular Cycle	Y	N	P	___
Pain during intercourse	Y	N	P	___
Painful Menstruation	Y	N	P	___
Excessive Flow	Y	N	P	___
PMS	Y	N	P	___
Birth Control	Y	N	P	___
Sexually Active	Y	N	P	___
Infertility	Y	N	P	___
Pelvic Inflammatory D	Y	N	P	___
PCOS	Y	N	P	___
Endometriosis	Y	N	P	___
Uterine Fibroids	Y	N	P	___
Sexual Difficulties	Y	N	P	___
Vaginal Itching	Y	N	P	___
Vaginal Discharge	Y	N	P	___
STD History	Y	N	P	___
Cervical Dysplasia	Y	N	P	___
Yeast Infections	Y	N	P	___
Menopausal Signs/Sx	Y	N	P	___
Age of first period				___
Age of menopause				___
Date of last PAP				___

Obstetric History: Currently Pregnant: (circle) Yes / No

Number of Pregnancies__________ Number of Live Births____________

Number of Births to Term________Number of Preterm Births_____________

Number of Miscarriages__________Number of Abortions__________________

Course of Pregnancy: (Spacing of pregnancy / Planned pregnancy / Parental attitudes towards pregnancy / Medical supervision of pregnancy / Complications of pregnancy / Prescriptions during pregnancy / Use of alcohol, street drugs, cigarettes, during pregnancy)______________________

____

____

____

____

Labor and Delivery: (Duration of Pregnancy / Name of Hospital or Midwife / Course of Labor / Duration of Labor / Use of anesthesia / Type of delivery)____

____

____

____

Postpartum Period: (Mother's health/ Reaction to baby/ Breast feeding)

____
____
____

Male Reproductive	Assessment	Comments
Sexually Active	Y N P	____________________
Sexual Difficulties	Y N P	____________________
Erectile Dysfunction	Y N P	____________________
Prostatitis	Y N P	____________________
BPH	Y N P	____________________
Testicular/Penile Pain	Y N P	____________________
Testicular Mass	Y N P	____________________
STD	Y N P	____________________
Discharge /Lesions	Y N P	____________________
Hernias	Y N P	____________________

Nutrition

Dietary Restrictions: (Religious / Vegetarian / Vegan / Other)___________
____

Food Allergies / Sensitivities: ____
____

Describe a Typical Day's Diet: (Include Time of Day)

Breakfast:____
____

Lunch:____
____

Dinner:____
____

Snacks:____
____

Beverages: (Include quantity)____

What type of water do you drink?______________________________________

How many glasses of water per day do you drink?_______________________

Do you eat dairy regularly? (circle) Y / N

Do you eat wheat regularly? (circle) Y / N

Do you eat products containing refined sugar regularly? Y / N

How many cups of coffee do you drink per day?_________________________

How many cups of tea do you drink per day?___________________________

How many cups of soda do you drink per day/week?____________________

How many times per week do you eat red meat?_________________________

How many times per week do you eat fish?_____________________________

How many times per day do you eat fruit?_____________________________

How many times per day do you eat vegetables?_________________________

Do you eat organic food? ____

How often do you eat out?____

What foods do you crave?____

Do you eat smoked foods?____

Lifestyle/ Habits

How many hours of sleep do you get?__________________________________
At what hour do you retire to sleep / rise from sleep?___________________
Do you wake rested? (circle) Y / N
Do you exercise regularly? (circle) Y / N Describe:
____
____
How is your energy level (on a scale of 1-10, 10 being the highest):_______
How is your stress level (on a scale of 1-10, 10 being the highest):_______
Do you enjoy your work: (circle) Y / N
Do you take vacations regularly: (circle) Y / N
How do you relax? (Television / Reading/ Other leisure activities):______
____
Do you use recreational drugs? (circle) Y / N Describe (drug / frequency of use): ____
____
Do you smoke cigarettes/cigars/pipe/chewing tobacco? (circle)
Y / N / Past
How many cigarettes smoked per day? ________________________________
How many years did you smoke?_____________________________________
When was your last drink of alcohol?_________________________________
How much did you drink at that time?_________________________________
Out of the last 30 days, about how many days would you say that you drank alcohol?____

Interpersonal Relationships / Resources

Describe your role in the family:_____________________________________
____
How do you get along with family / coworkers / neighbors / friends?____
____
____
Describe your support system:_______________________________________
____
To whom would you go for support with a problem at work, with your health, or a personal problem?_______________________________________
____
____
Is time spent along pleasurable or isolating?__________________________

Coping / Stress Management:

Kinds of stresses in life in last year:__________________________________

Change in lifestyle / current stress:____________________________________

Methods to try and relieve stress (success):______________________________

List the five most stressful events in your life. Do these still continue to affect you?____

Environmental Health

Do you have any environmental / chemical sensitivities?______________

Have you ever been around any of the following frequently or in large amounts in your work place, school or home?

IF YES:

a. Write the year(s) you were around it in the blank.

b. Put an X by any that caused symptoms when exposed.

Adhesives, sealers_________ Copy machine__________ Solvents_________
Cleaning agents_________ Toxic waste site ___________
Paints_________Carbonless paper __________ New furniture _________
Exhaust fumes ____________ Landfill_________ New carpet______________
Mold__________ Contaminated water__________ Pesticides Solvents, thinners______________Sick bldg/home________Lubricants
_________________ Cigarette smoke __________________
Other (list type/dates):

Do you have pets in the home?____
Is the smoking in the home?____
How is your home heated?____

Perception of Health

How do you define health?____

How do you view your situation now?___________________________________

What are your concerns?____

What are your health goals?____

What do you expect of your health care providers?______________________

____