



**CAMELBACK FAMILY
HEALTHCARE**

COMPLETE CARE FOR YOUR WELL-BEING

Name

Date

Adult Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions better. This form will not be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. **Thank you!**

Age _____ 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

- _____ Recent fevers/sweats
- _____ Unexplained weight loss/gain
- _____ Unexplained fatigue/weakness

Eyes

- _____ Change in vision

Ears/Nose/Throat/Mouth

- _____ Difficulty hearing/ringing in ears
- _____ Hay fever/allergies/congestion
- _____ Trouble swallowing

Cardiovascular

- _____ Chest pains/discomfort
- _____ Palpitations
- _____ Short of breath with exertion

Breast

- _____ Breast lump
- _____ Nipple discharge

Respiratory

- _____ Cough/wheeze
- _____ Coughing up blood

Gastrointestinal

- _____ Heartburn/reflux
- _____ Blood or change in bowel movement
- _____ Nausea/vomiting/diarrhea
- _____ Pain in abdomen

Genitourinary

- _____ Painful/bloody urination
- _____ Leaking urine
- _____ Nighttime urination
- _____ Discharge: penis or vagina
- _____ Unusual vaginal bleeding
- _____ Concern with sexual functions

Musculoskeletal

- _____ Muscle/joint pain
- _____ Recent back pain

Skin

- _____ Rash
- _____ New or change in mole

Neurological

- _____ Headaches
- _____ Memory loss
- _____ Fainting

Psychiatric

- _____ Anxiety/stress
- _____ Sleep problem

Blood/Lymphatic

- _____ Unexplained lumps
- _____ Easy bruising/bleeding

Endo

- _____ Cold/heat intolerance
- _____ Increase thirst/appetite

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 Dose (e.g., mg/pill) How many times per day

Medication	Dose (e.g., mg/pill)	How many times per day

Allergies or reactions to medications: _____

Date of your most recent **IMMUNIZATIONS:**

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

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) _____ Date _____ Abnormal? Yes No
Sigmoidoscopy or Colonoscopy _____ Date _____ Abnormal? Yes No
Women: Mammogram _____ Date _____ Abnormal? Yes No
Pap Smear _____ Date _____ Abnormal? Yes No
Dexascan (osteoporosis) _____ Date _____ Abnormal? Yes No
Men: PSA (prostate) _____ Date _____ Abnormal? Yes No

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates).

____ Heart disease: _____ High cholesterol _____ Cancer: (specify): _____
Type _____ Thyroid problem _____
____ Asthma/Lung disease _____ Kidney disease _____

SURGICAL HISTORY: Please list all prior operations (with dates):

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____	Depression/suicide _____
High cholesterol _____	Bleeding or clotting disorder _____
Cancer, specify type _____	Genetic disorders _____
High blood pressure _____	Asthma/COPD _____
Heart disease _____	Diabetes _____
Stroke _____	Other: _____

SOCIAL HISTORY

Tobacco Use

Cigarettes Never Quit Date _____

Current Smoker: packs/day _____ # of yrs _____

Other Tobacco: Pipe Cigar Snuf Chew
Are you interested in quitting? _____ No _____ Yes

Alcohol Use

Do you drink alcohol? _____No _____Yes # drinks/week _____
Is your alcohol use a concern for you or others?
_____No _____Yes

Drug Use

Do you use any recreational drugs? _____No _____Yes
Have you ever used needles to inject drugs?
_____No _____Yes

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)?
_____No _____Yes

SOCIOECONOMICS Occupation: _____ Employer: _____

Years of education/highest degree: _____ Marital Status: Single Partner/Married Divorced Widowed Other:

Spouse/partner's name: _____ Number of children/ages: _____

Who lives at home with you? _____

WOMEN'S HEALTH HISTORY # pregnancies _____ # deliveries _____ # abortions _____ # miscarriages _____

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

Are you interested in being screened for sexually transmitted diseases? _____No _____Yes

OTHER CONCERNS

Caffeine Intake: _____None _____Coffee/tea/soda cups/day

Weight: Are you satisfied with your weight?
_____No _____Yes

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? _____No _____Yes

Exercise: Do you exercise regularly? _____No _____Yes
What kind of exercise? _____

How long (minutes) How often? _____

If you do not exercise, why? _____

Safety: Do you use a bike helmet?
_____No _____Yes _____NA

Do you use seatbelts consistently? _____No _____Yes

Is violence at home a concern for you? _____Yes _____No

Have you ever been abused? _____Yes _____No

Do you have a gun in your home? _____Yes _____No

Have you completed a living will or or durable power of attorney for health care? _____Yes _____No