Adult Health History

Date: _____

Patient Name	Date of Birth
Gender	

Concerns for today	

Preventative Medicine	Date of last
Mammogram	
Cervical Cancer Screening – PAP/HPV Testing	
Bone Density	
Colorectal Cancer Screening Test – FIT/Cologuard/Colonoscopy	

Immunizations	Date of last
Flu	
Pneumonia	
Hepatitis A	
Hepatitis B	
Tetanus	
Shingles	

Patient Medical History

Have you ever had an abnormal cervical or anal pap result? (check one)	□ yes □ no
For Women: Date of Last Menstrual Period	Date: _____

Patient Illnesses and Conditions

Name	Check if you have now or have had in the past	Name	Check if you have now or have had in the past
Anemia		Epilepsy	
Arthritis (Osteo or Rheumatoid)		Heart Attack	
Asthma		Hepatitis (please list type)	
Cancer (please list type)		High Blood Pressure	
Diabetes (please list type) Diabetic Neuropathy: □ yes □ no Date of last screening: _____ Eye Exam Date: _____		Lung Disease	
Depression/Anxiety/Mental Health		Sexually Transmitted Infection	
Thyroid (Hyper or Hypo)			

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Location: eCW & CAREnet>Departments>Clinical Hub>Documents and Forms> Clinic Forms>Primary Specialty Care

Medications	Please either bring all your medication(s) to your visit **or** provide below a list all medication(s) you currently use and the dosages, including herbs, vitamins/supplements, aspirin, antacids, tonics, water pills, laxatives, tranquilizers, nerve pills, social drugs, and to other medication bought with or without a prescription.	
Name	**Dose**	**How often**

Medication Allergies and Reactions (please list)	
No known drug allergies	□ (check if applicable)

Surgical/Hospitalization History

Have you ever had a surgery? (check one)	□ yes □ no
Please provide date surgery and date	Date: _____ Surgery: _____ Date: _____ Surgery: _____
Have you ever been hospitalized (check one)	□ yes □ no
If so, for what reason (please print)	

Family History

Please indicate (check box) if any family members have had the following	**List Family members' relationship to patient: i.e. aunt, father, sister**
Asthma □	
Cancer- Type_____	
Depression/Suicide/Psychiatric (circle which)	
Heart Attack	
High Blood Pressure	
High Cholesterol	
Stroke	
Thyroid (Hyper or Hypo) (circle which)	
Tuberculosis	
Alcohol/Drug Abuse (circle which)	

Social History

Alcohol (beer, wine, liquor) Consumption	Number per day _____
Social/Recreational Drug usage	Name(s) _____ Number per day_____

Do you smoke?	□ yes □ no Start date: _____
Have you ever smoked?	Quite date: _____
If you do smoke, would you like information on quitting?	□ yes □ no □ n/a
Have you fallen in the last year with injury?	□ yes □ no