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ADULT HISTORY

Name_____

Date Completed_____ Date of Birth_____

Have you ever had:		
Yes	No	
		Smoking
		Diabetes
		High blood pressure
		A heart murmur
		Heart trouble
		Heart attack
		High cholesterol
		Seizures
		Stroke
		Asthma
		Emphysema
		Hay fever/sinus problem
		Pneumonia
		Ulcers
		Hepatitis
		Thyroid Problem
		Arthritis
		Anemia
		Sexually transmitted infection
		Urinary infection
		Cancer
		Breast lump
		Abnormal PAP smear
		Drug or alcohol abuse
		Depression

Do you exercise routinely?

☐Yes ☐No

ALLERGIES OR SEVERE REACTIONS TO MEDICATION OR FOOD
☐NONE

Medication/ food	Year of Reaction	What happened?

MEDICATIONS CURRENTLY TAKEN ☐ NONE

Medication	How Often	What for?

CHRONIC ILLNESS, SURGERY AND HOSPITILIZATIONS
(Do not include emergency room visits or childbirth)

Year	Why hospitalized/what surgery

STATEMENTS DESCRIBING YOUR USE OF MEDICATIONS:
(Check one or more)

- ☐ Buy medication on my own to treat myself
- ☐ Never take medications unless prescribed
- ☐ Usually want a medication prescribed for my illness
- ☐ Willing to try non-drug treatments
- ☐ Strongly prefer non-drug treatments
- ☐ Never take drugs or only as last resort

MENSTRUAL HISTORY

Age periods began_____
Spacing of periods_____
(No. of days from first day of one to first day of next)
Duration _____
(No. of days of bleeding)
Amount of flow ☐ Light
☐ Moderate
☐ Heavy
Age periods stopped_____

BIRTH CONTROL
(check the statement which applies)

☐ Use birth control currently
Which method? ☐ Condoms
☐ Birth control pills
☐ Other:_____
☐ Do not use birth control

OBSTETRICAL HISTORY

Number of times pregnant_____
Number of full term babies_____
Number of premature babies_____
Number of abortions or miscarriages_____
Number of living children_____
Number of stillborn babies_____

HEALTH SCREENING AND PREVENTION

What was the year of your last:

Tetanus shot _____

Blood pressure measurement _____

Cholesterol test _____

Colonoscopy _____
(tube inserted into the rectum to screen colon cancer)

WOMEN ONLY:

Pap smear _____

Mammogram (x-rays of the breast) _____

Breast exam by medical practitioner _____

Bone density test _____

SMOKING HISTORY

☐ Smoking cigarettes currently:
Packs/day_____
Year started_____
☐ Stopped smoking cigarettes
Year started_____
Year stopped_____
Packs/day when smoked_____
☐ Smoke pipe or cigars currently
☐ Smoked pipe or cigars in past
☐ Never smoked

ALCOHOL USE

☐ Do not drink alcohol currently
☐ Currently do drink (even occasionally)
How often:
☐ Less than 1 drink/month
☐ 1-3 drinks/month
☐ 1-3 drinks/week
☐ 1-3 drinks/day
How many drinks do you have at one time?
☐ 1 or 2 drinks
☐ 3 or 4 drinks
☐ 5 or more drinks
(One "drink" = one beer, one glass of wine, one shot of liquor or one mixed drink)

FAMILY HISTORY

	ALIVE			DEAD		
	Age	(check one) Well	Ill	Year of Death	Age at Death	Cause
Father						
Mother						
Brother(s)						
Sister(s)						
Spouse						
Children						