ADULT HEALTH HISTORY FORM

- Please answer all of the following questions to the best of your ability.

Patient's Name: ____ DOB: ______________

CHIEF COMPLAINT:
What is the reason for this appointment?____

HISTORY OF PRESENT ILLNESS:
Where does it hurt or bother you?____

What kind of pain? ____Sharp ____Dull ____Constant ____Intermittent

When did the problem start?____

Does anything make it better or worse? ____

Any other associated symptoms? ____

PAST MEDICAL HISTORY:
List any medical conditions that you are/have been treated for (asthma, high blood pressure, diabetes, etc.)

____

____

List previous surgeries:

____

____

List all medicine you are taking: 1.______________ 2.______________ 3.______________

4.______________ 5.______________ 6.______________ 7.______________

List drug allergies: ____

SOCIAL HISTORY:
Your occupation?____

Do you now or have you ever smoked or chewed tobacco?______________How much?______________

Do you now or have you ever drank alcoholic beverages?______________How much?______________

Do you have any of the following?

REVIEW OF SYSTEMS	NO	YES	REVIEW OF SYSTEMS	NO	YES
Anesthesia Complications	☐	☐	Kidney Disease	☐	☐
Arthritis	☐	☐	Lung Disease	☐	☐
Asthma	☐	☐	Migraines	☐	☐
Cancer	☐	☐	Muscle Aches	☐	☐
Diabetes	☐	☐	Rash	☐	☐
Easy Bleeding / Bruising	☐	☐	Seizures	☐	☐
Fevers	☐	☐	Snoring	☐	☐
Hearing Loss	☐	☐	Stomach Problems	☐	☐
Heart Disease	☐	☐	Unexplained Weight Loss	☐	☐
Heartburn / Reflux	☐	☐	Visual	☐	☐
High Blood Pressure	☐	☐	Wheezing	☐	☐
High Cholesterol	☐	☐	Other:	☐	☐

If "Yes" please describe ____

FAMILY HISTORY:
Do any of the diseases above run in your family?____

Are there any bleeding disorders or "free bleeders" in your family?______________________________