Adult Health History Form

REASON FOR VISIT: ____

PREFERRED PHARMACY: ______________________________ **PHARMACY LOCATION:** ______________________

ALLERGIES: ____

LIST ANY CURRENT MEDICATIONS (INCLUDE PRESCRIPTION, NON-PRESCRIPTION, VITAMINS, HERS, BIRTH CONTROL, ETC):

MEDICATION	DOSE (E.G. MG/PILL)	HOW MANY TIMES PER DAY?

MEDICATIONS: ARE YOU ON ANY OF THE FOLLOWING BLOOD THINNERS?

____ ASPRIN ____ COUMADIN ____ PLAVIX ____XARELTO

____ EFFIENT ____ BRILINTA ____ ELIQUIS ____ OTHER ____________________

HAVE YOU HAD THE INFULENZA VACCINE? YES NO PNUEMONIA VACCINE IN THE LAST 5 YEARS? (>65 YEARS OLD) YES NO

WHEN WAS YOUR LAST COLONOSCOPY? _______________ WHEN WAS YOUR LAST EGD? _________________________

WHEN WAS YOUR LAST MAMMOGRAM? _______________ HAVE YOU HAD BOTH COVID VACCINES? YES NO

SOCIAL HISTORY:

(CIRCLE ONE) MARRIED ENGAGED DOMESTIC PARTNER TOGETHER SEPERATED SINGLE WIDOWED

WHAT KIND OF WORK DO YOU DO: ____________________________ HIGHEST GRADE YOU COMPLETED: ____________

EXERCISE LEVEL: NONE OCCASIONAL, MODERATE, HEAVY DIET: ________________________

ALCOHOL INTAKE: NEVER OCCASIONAL DAILY

CAFFIENE INTAKE: NONE OCCASIONAL, MODERATE, HEAVY

SMOKING HISTORY: NEVER FORMER DAILY OCCASIONALLY AMOUNT: _________ HOW MANY YEARS: ___________

DO YOU VAP: YES OR NO CHEWING TABACCO: YES OR NO

HISTORY OF OR CURRENT DRUG USE: YES NO LIST ANY STREET DRUGS USED IN THE LAST YEAR: ________________________

DO YOU USE A SEATBELT ROUTINELY? YES NO DO YOU USE SUNSCREEN ROUTINELY? YES NO

WHO LIVES WITH YOU? ______________________________ NUMBER OF CHILDREN IN THE HOUSE: _______________

SEXUAL ORIENTATION: HETEROSEXUAL HOMOSEXUAL BISEXUAL SEXUALLY ACTIVE: YES NO

REV. 1/2017, 3/2016, 7/2020

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PLEASE SELECT THE CONDITIONS BELOW THAT APPLY TO YOU OR A FAMILY MEMBER (PLEASE SPECIFY MATERNAL OR PATERNAL SIDE OF FAMILY AND RELATION TO YOU)

Example: Paternal side, aunt; maternal side grandmother; brother/sister

	SELF	**FAMILY** Mother (M) Father (P) Relation to you		**SELF**	**FAMILY** Mother (M) Father (P) Relation to you
ADD or ADHD			Heart Problems		
Allergies			Hepatitis		
Anxiety Disorder			High Blood Pressure		
Arthritis			High Cholesterol		
Asthma			Kidney Problems		
Bipolar Disorder			Liver Disease		
Birth Defect or Inherited Disease			Mental Retardation (Chromosome Disorders)		
Breast Problems			Lung Problems		
Cancer			Osteoporosis		
Cystic Fibrosis			Psychiatric Illness		
Depression			Pulmonary Embolism		
Diabetes			Seizures/Epilepsy		
Diverticulitis			Skin Problems		
Endometriosis			Stroke		
Fibromyalgia			Thyroid Problems		
GERD/Reflux			Tuberculosis		
Headaches/Migraines			Varicose Veins		
Heart Disease			Vision or Eye Problems		

Any other conditions not listed above: ____

SURGERIES (LIST TYPE OF SURGERY AND APPROXIMATE YEAR INCLUDING C-SECTION, TUBAL, D&C, BLADDER SUSPENSION):

Surgery Type and Year	Surgery Type and Year

List any hospitalizations not related to childbirth:

_______________________________ _______________________________