alivation HEALTH

Adult History

Patient Name: _____ Date: _____

Date of Birth _____ Age _____ Marital Status (circle one) S __M__D__W_

Occupation _____ Years of Education _____ Pref. Pharmacy _____

List all Medications you now take, INCLUDE prescribed, over- the-counter, vitamins, drops and topicals:

Medication Dose Times daily

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergies: (list medication and reaction) _____

Do you have an Advance Directive? Y N
If yes, has a copy been furnished? Y N Denied

Operations: (list any operations and dates performed) _____

Other hospitalizations and illnesses: _____

Other illnesses (chronic) _____

Health Review (Mark the ones that best describe you)

Tobacco:	___None	___Pipe/Cigar	___Chew	___Cigarettes	___Amount daily	___How Long?	___Quit?
Alcohol:	___1/week-2/day	___Weekends	___None	___Over 2 drinks daily		___Quit	
Coffee:	___0-4 cups daily	___More: _____					
Meals:	___Regular low-fat	___Regular	___Often skip	___Fast food			
Exercise:	___Regular	___Occasionally	___Rarely	___No			
Use of seat belts:		___Yes	___Occasionally	___No			
Use of Street Drugs:		___No	___Yes Details:_____	Last tetanus shot date: _____			

Family History (Mark the ones that best describe your family)

	Age	Deceased	Alcoholism	Arthritis	Asthma	Bleeds Easily	Cancer	Diabetes	Epilepsy	Heart Disease	High Blood	High Cholester	Kidney Disease	Mental Illness	Migraine	Stroke	TB	Thyroid Disease	Other
Father																			
Mother																			
Bro/Sis																			
Bro/Sis																			
Spouse																			
Child																			
Child																			
Child																			

Please provide more details of Cancer, Mental Illness or other, including age of onset: _____

Patient Name:_____Date of birth: _____

Have you had the following symptoms or problems either in the past or now?
Please check the appropriate boxes.

General

Current	Past	
☐	☐	Anemia
☐	☐	Unexplained weight gain
☐	☐	Unexplained fatigue/weakness
☐	☐	Thyroid problems
☐	☐	Diabetes or high blood sugar
☐	☐	Fever or chills
☐	☐	Unusual lymph glands
☐	☐	Cancer
☐	☐	Rashes
☐	☐	Risk Factors for AIDS
☐	☐	Sleep difficulties
☐	☐	None of the above

Head

Current	Past	
☐	☐	Migraine
☐	☐	Frequent, severe or unusual headaches
☐	☐	Change in vision
☐	☐	Wear glasses/contacts
☐	☐	Glaucoma
☐	☐	Hearing difficulty
☐	☐	Nosebleeds
☐	☐	Sinus problems
☐	☐	Hair loss
☐	☐	Dentures/bridge
☐	☐	Bleeding gums
☐	☐	Persistent hoarseness
☐	☐	Difficulty swallowing
☐	☐	Hay fever
☐	☐	None of the above

Lungs

Current	Past	
☐	☐	Shortness of breath
☐	☐	Asthma or emphysema
☐	☐	Frequent cough
☐	☐	Coughing up blood or phlegm
☐	☐	Tuberculosis
☐	☐	Recurrent pneumonia or bronchitis
☐	☐	Wheezing
☐	☐	None of the above

Heart

Current	Past	
☐	☐	Heart murmur
☐	☐	Heart failure
☐	☐	Waking up at night due to shortness of breath
☐	☐	High blood pressure
☐	☐	Rheumatic fever
☐	☐	Chest pain, pressure, discomfort
☐	☐	Heart attack
☐	☐	Irregular heartbeat
☐	☐	Swelling in the legs
☐	☐	Calf pain
☐	☐	Racing Heart
☐	☐	Blood transfusion
☐	☐	Easy bruising or bleeding
☐	☐	None of the above

Gastrointestinal

Current	Past	
☐	☐	Indigestion or heartburn
☐	☐	Ulcer
☐	☐	Unexplained abdominal pain
☐	☐	Vomiting or bleeding
☐	☐	Hepatitis or liver problems
☐	☐	Frequent diarrhea
☐	☐	Constipation
☐	☐	Hemorrhoids
☐	☐	Rectal bleeding
☐	☐	Black tarry bowel movements
☐	☐	Change in bowel movements
☐	☐	None of the above

Urinary

Current	Past	
☐	☐	Bladder or kidney infection
☐	☐	Kidney stones
☐	☐	Burning with urination
☐	☐	Slow urine flow
☐	☐	Difficulty starting or controlling urine stream
☐	☐	Blood in urine
☐	☐	Venereal disease
☐	☐	Sexual problems
☐	☐	None of the above

Men Only

Current	Past	
☐	☐	Prostate problems
☐	☐	Discharge from penis
☐	☐	Lump in testicles
☐	☐	Erectile dysfunction
☐	☐	None of the above

Women Only

Current	Past	
☐	☐	Breast lump
☐	☐	Discharge from nipple
☐	☐	Irregular periods
☐	☐	Abnormal vaginal bleeding or spotting
☐	☐	Abnormal PAP test

Last Pap Date:_____
Age at onset of periods_____
Cycle:_____Days
(from start to start)
Birth control method _____
Number of pregnancies_____
Number of children _____
Number of living children _____
Number of adopted children _____
None of the above _____

Bones/Joints/Muscles

Current	Past	
☐	☐	Painful or swollen joints
☐	☐	Persistent back or neck pain
☐	☐	Muscle cramps
☐	☐	Osteoporosis
☐	☐	None of the above

Psychological

Current	Past	
☐	☐	Suicidal thoughts
☐	☐	Suicide attempt
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Crying spells
☐	☐	Memory problems
☐	☐	Sleep problems
☐	☐	Job or family difficulty
☐	☐	Loss of interest in previously enjoyable activities
☐	☐	None of the above

Neurological

Current	Past	
☐	☐	Seizure or epilepsy
☐	☐	Stroke
☐	☐	Numbness of face, arm or leg
☐	☐	Weakness of face, arm or leg
☐	☐	Difficulty with speech
☐	☐	Fainting or loss of consciousness
☐	☐	None of the above

Other

Current	Past	
☐	☐	Have you seen a specialist?

Name of specialists'
_____
_____
_____

Do you currently use a glucometer or other medical equipment? _____
Brand of glucometer _____
Other medical equipment _____
_____

Do you feel well? _____

Do you have anything else to add to your medical history?
_____
_____
_____
_____
_____
_____
_____
_____

Please complete both sides