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NEW PATIENT HEALTH HISTORY – ADULT

Today's Date _____

Name _____

Date of Birth _____ Age _____

Feale or Male or Other _____ Blood Type, if known _____

Current Street Address _____

City, State, Zip _____

Best Phone(s): _____

Email _____ OK for online dispensary? Yes No

Occupation(s): _____

Living Situation: Single, or live with: Spouse/Partner, Children, Pets, Parents, Others:

_____

Person to Notify in case of Emergency _____

Relationship to You _____ Phone _____

How did you hear about this office? _____

ALL INFORMATION YOU GIVE WILL REMAIN CONFIDENTIAL UNLESS YOU AUTHORIZE ITS RELEASE.
GOVERNMENT EMPLOYEES AND INSURANCE COMPANIES MAY REQUIRE RELEASE OF MEDICAL RECORDS.

MAIN CONCERNS Today**:**

_____

_____

_____

_____

CURRENT HEALTH CARE TEAM (general, specialists, dental, eye**):**

_____

_____

_____

_____

_____

RELEVANT WORKUP (What labs, tests, or imaging have been done to evaluate these concerns?)

_____

_____

_____

Date _____ Name _____

MEDICATIONS, prescription and over-the-counter, with dosages:

_____

_____

_____

_____

_____

SUPPLEMENTS, with dosages:

_____

_____

_____

_____

_____

ALLERGIES/ADVERSE REACTIONS to foods, animals, dust, pollens, drugs, mold, or other agents:

Allergen Symptoms

_____

_____

_____

_____

DENTAL/VACCINATION HISTORY

When (Date or approx. age) What Procedure or Vaccination

_____

_____

_____

_____

_____

SCREENING OR DIAGNOTIC TESTS, if applicable.

What is the approximate date of your last, MOST RECENT Blood Test _____

Women/Pap test _____ Men/PSA test _____ Mammogram _____

Colon or Sigmoid-oscopy _____

Bone density test and kind (DEXA, ultrasound, of what area/s)

_____

Diagnostic imaging such as x-ray, MRI, ultrasound, EKG, and reason why:

_____

_____

Date _____ Name _____

REVIEW OF SYSTEMS: Please circle symptoms that are current or recent.

CONSTITUTION
Fatigue/Tiredness, unusual weight gain or weight loss, appetite changes, fever, chills, night sweats

SKIN
Rash, itching, dryness, flaking, oily skin, sores, changes in moles, growths or bumps, hair loss/thinning, brittle or problem nails.

BLOOD & LYMPH
Anemia, swollen lymph nodes, frequent nose bleeds, easy bruising.

NERVOUS SYSTEM
Headaches, migraines, spinning sensation, light-headedness, fainting, unsteady gait, poor balance, numbness, tingling, tremors, less ability to focus and concentrate, poorer memory, altered thinking abilities, moodiness or irritabilitiy, concussion.

EYES
Double vision, other vision problems, eye pain, eye redness, tearing, itching, dryness, lumps, eyelid or lash problems, floaters, flashes.

EARS
Ringing in ears, poor hearing, earache or pain, itching, dizziness, hearing aids.

NOSE & SINUSES
Frequent colds, nasal congestion/stuffiness, runny nose, post-nasal drip, frequent sinusitis, sinus headaches, loss of smell, hayfever/allergies, snoring, nasal polyps.

MOUTH & THROAT
Frequent sore throats, sore or bleeding gums, grinding teeth, mouth sores, hoarseness, decreased sense of taste, dental problems, difficulty swallowing, neck lumps.

BREASTS
Lump(s), change in shape or contours, change in size, tenderness or pain, nipple discharge, skin changes.

LUNGS
Difficulty breathing (while lying down, on exertion, in middle of night, on taking a deep breath), shortness of breath, coughing, wheezing, frequent bronchitis, asthma, other lung disorders.

HEART & VESSELS
Chest pain, heartbeats that are skipped/fast/extra strong, irregular heartbeats, high blood pressure, varicose veins, clotting problems, leg cramps when walk, ankle or leg swelling, leg pain, cold/discolored extremities, heart murmur, angina, history of heart attack or stroke/TIA.

DIGESTION
Difficulty swallowing, acid reflux, ulcer, nausea, vomiting, diarrhea, constipation, abdominal bloating/distension, abdominal pain or cramping, excessive gas, hemorrhoids, rectal bleeding, change in stool, gallstones, jaundice, poor digestion.
Do you use antacids, laxatives, or aspirin?

KIDNEYS & BLADDER
Frequent bladder infections. Loss of bladder control.
Urination that is difficult, painful, urgent.
Increased or decreased frequency of urination.
Awaken to urinate at night. Loss of bladder control.
Change in total daily urine output.
Change in color or smell of urine. Kidney stones.
Difficulty starting stream, reduced force of stream.

MUSCULO-SKELETAL
Problems with bones, joints, &/or muscles at:
neck, back, hips, knees, ankles, feet, shoulders, elbows, wrists, hands.
Aching, stiffness, swelling, redness, limited range of motion, reduced daily activities, injuries, dislocations, osteoporosis, muscle weakness, muscle cramps.

ENDOCRINE/HORMONES
Extremely thirsty, hungry, and urinate more than 3 quarts per day.
Nervousness, sweaty palms, shakiness, mental confusion, headaches.
Feel hot or cold most of the time, more than others.
Easy to lose or gain weight, brittle or thinning hair, dry or perspiring skin, irregular menstrual periods, unusual difficulty thinking, unusual depression.
Diabetes, hypoglycemia, goiter, thyroid problems, adrenal problems.

Date _____ Name _____

FAMILY HEALTH HISTORY (please include age now or at death, if applicable)
Please indicate if any family members have had heart disease, high blood pressure, stroke, diabetes, asthma, allergies, eczema, cancer, autoimmune disorder, epilepsy, mental illness, alcoholism/drug addictions, or other significant health problems.

Relative, their Age	Health conditions
Your Mother, age	
Your Father	
Your Siblings	
Your Children	
Your M. Grandparents	
Your P. Grandparents	

CHRONOLOGICAL SUMMARY OF PAST HEALTH HISTORY, the highlights, from as early in childhood as you can recall, to the present. Don't worry if list is slightly out of order. Include major stresses/life events, injuries, accidents, surgeries, major illnesses, blood transfusions, general recurrent problems (like allergies, rashes, digestive issues), past exposure to toxins, and mental/emotional problems. Note the approximate date by year(s), or age(s), at which these problems occurred.

Your Age, or Date by Year(s) Health Condition/Event