Teton Radiology *advanced medical imaging*
2001 S. Woodruff, Suite 17, Idaho Falls, ID 83404 • tel (208) 524-7237
425 E. 4th N., Rexburg, ID 83440 • tel (208) 356-4888

Adult Health History

Name	Date of birth	Age	Date

Your answers on this form will help your healthcare provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best answer. Thank you.

Describe the condition or complaint that brings you to our clinic:
When did it start? _____

What symptoms are you having? _____

What have you tried? _____

Any other information: _____

Height: _____ft _____in

Weight: _____lbs.

Are your pregnant? ☐ Yes ☐ No

Primary care provider

Review of Systems *Have you ever had any of the following (check all that apply)*

Neuro:
□ Confusion/Memory Loss
□ Anxiety/Depression
□ Stroke
□ Numbness/Tingling/Neuropathy
□ Disease: _____
□ Dementia

Heart:
□ Irregular
□ Murmur
□ Heart Attack
□ CHF
□ Pacemaker
□ Edema
□ Coronary Artery Disease

Lungs:
□ SOB
□ COPD
□ Asthma
□ Coughing
□ Sleep Apnea
□ O2 Use
□ Wheezing

Skin:
□ Wounds/ulcers
□ Rashes
□ Lesions
□ Fragile Skin
□ Itching
□ Varicose Veins

Back:
□ Pain/Chronic Pain
□ Acute Injury
□ History of Vertebral Fractures
□ Surgery: _____
□ Imaging: _____

Vascular:
□ History of Stents
□ PAD – Peripheral Arterial Disease
□ Varicose Veins
□ Cool or Cold Feet
□ Red, Purple, or Blue Feet
□ Leg Ulcer
□ Using Compression Socks
Date: _____

HEENT:
□ Hard of Hearing
□ Sinus Problems
□ Wearing Glasses/Contact Lenses

Abdomen/GI:
□ Tenderness
□ Liver Disease/Cirrhosis/Fatty Liver
□ Reflux/GERD
□ Constipation

Mobility:
□ History of Falls
□ Uses Cane
□ Uses Walker
□ Uses Wheelchair

Other:
□ Blood Thinner:
Name: _____
Why? _____
□ Use of Osteoporosis medication
□ History of Vertebral Fractures
□ Diabetes
□ Type 1 □ Type 2
HbA1c: _____
Date: _____
Managing Dr. : _____

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Allergies *Do you have allergies or reactions to the following, please list*

Medications	Reaction	Foods	Reaction

Medication

Prescriptions and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication/Vitamin Supplement	Dose/Strength (e.g., mg/pill)	How Many Times Per Day	Reason for Taking/Diagnosis

Medical History

Major illnesses: (i.e., high blood pressure, high cholesterol, depression, etc.)	Year of diagnosis	Doctor treating
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Surgeries

Surgeries	Year of surgery	Reason for surgery
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Adult Health History

Family History

Mother ☐ Living ☐ Deceased	Major Illnesses
Father ☐ Living ☐ Deceased	Major Illnesses
# brothers alive: _____ # brothers deceased: _____	Major Illnesses
# sisters alive: _____ # sisters deceased: _____	Major Illnesses
# children alive: _____ # children deceased: _____	Major Illnesses

Social History

Tobacco use

Cigarettes ☐ Never ☐ Quit date: _____ ☐ Current smoker: _____ packs/day; # of years _____

Other tobacco; ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ Vape

Are you interested in quitting? ☐ Yes ☐ No What have you tried in the past?

Alcohol use

Do you drink alcohol? ☐ Yes ☐ No # drinks/week _____

Is alcohol use a concern for you or others? ☐ Yes ☐ No History of Alcoholism? ☐ Yes ☐ No

Caffeine ☐ Yes ☐ No

Narcotic Drug Use ☐ Yes ☐ No

Socioeconomics

Occupation – if retired, previous occupation

☐ Retired

Employer

Marital status ☐ Name (if applicable): _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner or Significant Other

Who do you live with? # Children	Where? ☐ Home/Apartment ☐ Assisted Living ☐ Skilled Nursing Facility ☐ Other

In the past month have you had little interest or pleasure in doing things, or felt down, depressed, or hopeless?

☐ Yes ☐ No

Do you have an Advanced Care Plan (Living Will)?

☐ Yes ☐ No

Who is your surrogate decision maker?

Name: Relationship: ☐ None

Do we have permission to share your treatment information with them?

☐ Yes ☐ No

Signature

Patient signature	Date