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.

What condition brings you to our clinic today? _____

When did it start? _____

Other concerns:_____

Height: _____ft _____in Weight: _____lbs. Are your pregnant? ☐ Yes ☐ No	Primary care provider

Social History

Tobacco use

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

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

Illegal drug use? ☐ Yes ☐ No

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

Do you have an Advanced Care Plan (Living Will)? ☐ Yes ☐ No

Would you provide a copy? ☐ Yes ☐ No

Who is your surrogate decision maker?

Name: Relationship: ☐ None

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

☐ 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? Where?

☐ Home/Apartment ☐ Assisted Living ☐ Skilled Nursing Facility ☐ Other

Family History

Mother ☐ Living ☐ Deceased	Major Illnesses
Father ☐ Living ☐ Deceased	Major Illnesses
# children alive: _____ # children deceased: _____	Major Illnesses
Siblings # living: _____ # deceased: _____	Major Illnesses

Adult Health History

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

Medications	Reaction	Allergen	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.		

Patient Signature

Date