Adult Health History

Date:_____

Name: _____

Date of Birth:_____ **Occupatio**n:_____

Chronic Medical Conditions (Check all that apply):

___Asthma ___Diabetes ___Hypertension

___High blood pressure ___Hypothyroidism ___Emphysema

___Cancer (type_____) ___Arthritis ___Heart disease

___Allergies ___Other: (Please list)_____

Are you allergic to any drugs? ___No

___Yes (Please list drug(s) and reaction):_____

_____

List all hospital stays/ surgeries and their dates to the best of your recollection:

List all Medications you are currently taking, including over the counter and herbal supplements:

Family History

Have your parents or siblings had any of the following illnesses? (Check all that apply):

___Colon cancer ___Breast Cancer ___Other cancer (List type(s)):_____

___Diabetes ___High blood pressure _____

___High cholesterol ___Heart disease _____

Immunization History

Please check all immunizations which you have had and list the date you last received them to the best of your recollection:

___Tetanus (Date:_____) ____Pneumonia (Date:_____)

___Measles/Mumps/Rubella (Date:_____)

Social History

Do you smoke? ____No ___Yes (Packs per day_____. Number of years_____)

How much alcohol do you drink in a week? ____None ____Glasses/Bottles

Do you use recreational drugs? ___No ___Yes (I use _____)

I certify that the above information is correct to the best of my knowledge:

_____ _____
(Signature) (Date)

_____
(Printed Name)