Adult Self History Form

Name : _____ What would you like to be called ? _____ DOB : _____ Age : _____
Sex: _____ Race : _____ Please check one : Single _____ Married _____ Divorced _____ Separated ____ Widowed _____
Who do you currently live with ? Alone _____ Family _____ Friends _____ Significant other/Spouse _____ Other _____
Current job: _____ Previous job: _____ Highest level of education? _____

MEDICATIONS (please include all prescriptions, over-the-counter, vitamins, and supplements)

Name of medication (ex. Simvastatin)	Dosage and instructions (ex. 30mg, take 1 tablet daily)

ALLERGIES TO ANY MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES? YES _____ NO _____
(if YES, please list the name of medication and what type of reaction) (ex. Hives) _____
_____
_____
_____

SURGERIES/HOSPITALIZATIONS- Please list date and details; indicate either surgery or hospitalization

Date	Surgery / Hospitalization	Reason / Details and Locations

IMMUNIZATIONS Best guess to the last date or year you received the following;

Tetanus	_____	Chicken Pox disease or shot	_____	Flu	_____
Hepatitis B	_____	Gardasil	_____	COVID	_____
Pneumonia	_____	TB Screening	_____	Booster	_____

HEALTH MAINTENANCE Best guess to the last date or year you received the following;

Colonoscopy _____ with Dr _____ Pap smear _____ OB GYN or Primary doctor?_____
Mammogram _____ Where? _____ Bone Density _____ Where? _____
Last Eye Exam _____Where? _____ Last Wellness/physical _____

Please circle one - Do you consider yourself: Underweight Normal Weight Overweight Obese

What kind of exercise do you do? _____ How often? _____
Do you wear seat belts? YES or NO Do you use sunscreen? YES or NO
Do you feel safe at home? YES or NO Do you text while driving? YES or NO
Do you drink coffee/soda/tea? YES or NO If yes, how many cups/cans a day? _____

What type of birth control is used between you and your partner? _____

Which of the following conditions are currently being treated or have been treated for in the past?

___ Alcoholism
___ Angina (chest pain)
___ Arthritis
___ Atrial Fibrillation
___ Backache
Upper___ mid___ Low___
___ Bipolar
___ Colon Cancer
___ Prostate Cancer
___ Chronic Kidney Disease
___ Circulatory System Disorder
___ Congestive Heart Failure
___ Coronary Artery Disease
___ Headaches
___ Auto-immune Disorder

___ Diabetes on insulin
___ Diverticulosis
___ Emphysema
___ Erectile Dysfunction
___ Glaucoma
___ Hearing Loss
___ Herniated Disc
___ High Lipids
___ Hypertension
___ Hypothyroidism
___ Long-term Meds
___ Low Testosterone
___ Memory Loss
___ Mitral Valve Insufficiency

___ Myalgia/Fibromyalgia
___ Sleep Apnea
___ Osteoarthritis
___ Polycystic Ovaries
___ Renal Dialysis
___ Seizure Disorder
___ Past Smoker
___ Systemic Lupus
___ Use of Insulin
___ Visual Impairment
___ Vit D Deficiency
___ Acne
___ Anemia
___ Anxiety
___ Depression

___ Asthma
___ ADD/ADHD
___ Bariatric Surgery
___ Breast Cancer
___ Lung Cancer
___ Chronic Bronchitis
___ Chronic Pain
___ Colon Polyps
___ COPD
___ Diabetes Type 2
___ Eczema/dermatitis
___ GERD
___ GOUT
___ Pacemaker/ Implanted devices

___ Heart Attack
___ High Cholesterol
___ Hypertension
___ Irritable bowel
___ Macular Degen.
___ Migraine
___ On Blood Thinner
___ Osteoporosis
___ Rayounds
___ Restless leg
___ Chronic Sinusitis
___ Current Smoker
___ Stroke
___ Oxygen Use
___ Vit B12 deficient

___ Other_____

FAMILY HISTORY - Please put a checkmark in all applicable boxes

Were you adopted? YES or NO

Illness	Father	Mother	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Child M or F
Anemia									
Asthma									
Bleeding/Clotting Disorder									
Breast Cancer									
Lung Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
Other Cancer									
Colon/Bowel Problem									
Depression/Anxiety									
Diabetes									
Drug/Alcoholism									
Glaucoma									
Heart Attack									
Heart Disease									
High Blood pressure									
High cholesterol									
HIV/AIDS									
Kidney disease									
Liver Disease									
Seizure/Epilepsy									
Stroke									
Suicide									
Thyroid Disease									
Other:___									

OB / GYN HISTORY

Age of first menses: _____ Date of last Period: _____ Length of Cycle: _____ Is this normal for you: YES or NO
Do you suffer from PMS ? YES or NO Have you ever had an abnormal pap ? YES or NO If Yes, date and result _____
Pregnancies: Total Number _____ Full Term _____ Miscarriages _____ Abortions _____ Premature _____ Tubal _____
Any complications? _____

SOCIAL HISTORY

Are you sexually active ? YES or NO If yes, are your sexual partners ? MEN WOMEN BOTH
Have you ever been diagnosed with a sexually transmitted disease ? YES or NO Diagnosis: _____
Do you smoke? YES or NO How many a day? _____ How many a week? _____ Started _____ Many years?_____
Do you drink alcohol? YES or NO How many a day? _____ How many a week? _____ Which Liquor Beer Wine
Have you ever had a problem with alcohol in the past? YES or NO Explain _____
Has anyone ever expressed concerns about your alcohol use? YES or NO Explain _____
Do you currently use any recreational drugs including marijuana? YES or NO What types? _____
Have you ever had a drug problem in the past (prescription drug addiction/illegal drug use)? YES or NO
if yes, explain _____
_____