PrairieStar Health Center

Patient Name________________________
Date Of Birth________________________
Date ________________________

(Patient Label)

ADULT HEALTH HISTORY FORM

Present health concerns________________________

____

____

Medications: Prescription, non-prescription, vitamins, herbs

Medication	Dose	Times A Day

Allergies or reactions to medications________________________

____

Date of your most recent immunizations:

Hepatitis A_______ Hepatitis B_______ Flu_______
Meningitis_______ Tetanus_______ MMR_______
Pneumovax_______ Varicella_______ Tdap_______

Health Maintenance Screening Tests

Lipid (Cholesterol) : Date_________ Abnormal ☐ Yes ☐ No
Colonoscopy: Date_________ Abnormal ☐ Yes ☐ No
Mammogram: Date_________ Abnormal ☐ Yes ☐ No
Pap Smear: Date_________ Abnormal ☐ Yes ☐ No
Dexascan: Date_________ Abnormal ☐ Yes ☐ No
Men: PSA (Prostate) Date_______ Abnormal ☐ Yes ☐ No

Personal Medical History (Please indicate whether you have has any of the following medical problems:

_____Heart Disease
_____High Blood Pressure
_____Asthma/Lung Disease
_____High Cholesterol
_____Cancer (type)________________________
_____Kidney Disease
_____Thyroid Problems
_____Diabetes
_____Other

Surgical History

Please list all prior operations with dates

____

____

____

Family History

Please indicate the status of your immediate family members (parents, grandparents, aunt, uncle, siblings) with any of the following condition:

Alcoholism________________________
Cancer (specify)________________________
Heart Disease________________________
Depression/suicide________________________
Genetic Disorder________________________
Diabetes________________________
High Cholesterol________________________
High Blood Pressure________________________
Stroke________________________
Bleeding or clotting disorder________________________
Asthma/COPD________________________
Seizure________________________
Other________________________

Social History

Tobacco Use

Cigarettes ☐ Never ☐ Quit Date__________
☐ Current Smoker: Packs/day_______ # of years_______
Other tobacco: ☐ Pipe ☐ Cigar ☐Snuff ☐ Chew
Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use

Do you drink alcohol? ☐ Yes ☐ No
Is your alcohol use a concern for you or others? ☐ Yes ☐ No

Drug Use

Do you use recreational drugs? ☐ Yes ☐ No
Have you ever used needles to inject drugs? ☐ Yes ☐ No
Have you ever had a blood transfusion? ☐ Yes ☐ No
Do you have any tattoos? ☐ Yes ☐ No

Sexual Activity

Sexually active? ☐ Yes ☐ No ☐ Not currently
Birth control method________________________
Have you ever had any sexually transmitted diseases? (STD's)
☐ Yes________________________ ☐ No
Are you interested in being screened for STD's? ☐ Yes ☐ No

PLEASE COMPLETE BACK SIDE ➔ OVER

Other Concerns:

Caffeine Intake: ☐ None ☐ Coffee/tea/soda ______cups/day

Weight: Are you satisfied with your weight?

☐ Good ☐ Fair ☐ Poor

Do you eat or drink four servings of dairy or soy daily or take calcium supplements? ☐ Yes ☐ No

Would you like information on weight loss? ☐ Yes ☐ No

Exercise

Do you exercise regularly? ☐ Yes ☐ No

What kind of exercise?______________________________

How long (minutes) __________ How often?____________

If you do not exercise, why?__________________________

Safety

Do you use a seatbelt consistently? ☐ Yes ☐ No

Is violence at home a concern for you? ☐ Yes ☐ No

Have you ever been abused? ☐ Yes ☐ No

Do you have a gun in your home? ☐ Yes ☐ No

Depression

Do you have problems falling asleep? ☐ Yes☐ No

Do you feel sad or blue? ☐ Yes ☐ No

Have you had a decrease in appetite? ☐ Yes ☐ No

Have you lost interest in former activities/☐ Yes ☐ No

Have you had thoughts of death or suicide? ☐ Yes ☐ No

Do you have problems with concentration and/or decision making abilities? ☐ Yes ☐ No

Women's Health History

Number of pregnancies______________________________

Number of deliveries________________________________

Number of abortions________________________________

Number of miscarriages______________________________

Age at start of periods_______________________________

Age at end of periods________________________________

Socioeconomics

Occupation_______________________________________

Employer____

Years of education/highest degree____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of children_________________________________

Review Of Symptoms (Please check any current symptoms)

Constitutional

_____Recent fevers/sweats

_____Unexplained weight loss/gain

_____Unexplained fatigue/weakness

Eyes

_____Change in vision

Ears/Nose/Throat/Mouth

_____Difficulty hearing/ringing in ears

_____Hay fever/allergies/congestion

Cardiovascular

_____Chest pains/discomfort

_____Palpations

_____Short of breath with exertion

Breast

_____Breast lump

_____Nipple discharge

Respiratory

_____Cough/wheeze

_____Coughing up blood

Gastrointestinal

_____Heartburn/reflux

_____Blood or change in bowel movement

_____Nausea/vomiting/diarrhea

_____Pain in abdomen

Musculoskeletal

_____Muscle/joint pain

_____Recent back pain

Skin

_____Rash

_____New or change in mole

Neurological

_____Headaches

_____Memory loss

_____Fainting

Psychiatric

_____Anxiety/stress

_____Sleep problems

Blood/Lymphatic

_____Unexplained lumps

_____Easy bruising/bleeding

Endo

_____Cold/heat intolerance

_____Increase in thirst/appetite

____

Provider Signature Date