ADELANTE HEALTHCARE

HEALTH HISTORY
18 AND OLDER

AD06.PT.FRM

Patient Name: _____ Date of birth: (mm/dd/yyyy): ____/____/_____ **Date:**_____

CHECK CONDITIONS BELOW THAT YOU HAVE NOW OR HAVE HAD IN THE PAST.

- ☐ Alcoholism/drug addiction
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding problem
- ☐ Blood clot in leg or lung
- ☐ Cancer type:_____
- ☐ Depression
- ☐ Diabetes – type: _____
- ☐ Epilepsy /Seizures
- ☐ Genital discharge / pain
- ☐ Heart Disease / Attack
- ☐ Hepatitis – type: _____
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Lung disease
- ☐ Mental health diagnosis
- ☐ Migraines
- ☐ Rheumatic fever
- ☐ Sexually transmitted infection
- ☐ Stomach problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid _____
- ☐ Ulcer
- ☐ Other _____

HOSPITALIZATION, SURGERY, SERIOUS INJURIES

HOSPITALIZATION, SURGERY, SERIOUS INJURIES	YEAR

FAMILY HISTORY

Check if any family members have had any of the following.
Write relationship to you in the space.

- ☐ Alcoholism, drug addiction
- ☐ Asthma ☐ Cancer – type:_____
- ☐ Depression /Mental health problem
- ☐ Diabetes-type:
- ☐ Epilepsy /Seizures
- ☐ Heart disease ☐ High blood pressure
- ☐ Hepatitis-type:_____
- ☐ Lung disease (emphysema/TB)
- ☐ Stroke ☐ Thyroid ☐ Other_____

ALLERGIES:

CURRENT MEDICATIONS: Include prescription, vitamins and over the counter / herbal preparations.

WOMEN's Health: First menstrual period (age):_____

Last menstrual period: _____

Menopause year: _____

OB History: Pregnancies:_____ Living Children:_____

Miscarriages/ Abortions:_____

Birth Control: ☐ none ☐ pills Other: _____

Last mammogram:_____ ☐ Normal ☐ Abnormal

Last Pap Smear: _____ ☐ Normal ☐ Abnormal

Last Colonoscopy: _____ ☐ Normal ☐ Abnormal

MEN's Health:

Last Colonoscopy: _____ ☐ Normal ☐ Abnormal

SOCIAL HISTORY

Relationship status:

☐ Single ☐ Spouse/partner ☐ Widowed

Alcohol

☐ Yes ☐ No

If yes, type: _____ frequency:_____

Tobacco

☐ Yes ☐ No If yes, type:_____

per/times day: _____ since: _____

If yes, would you like help quitting? ☐ Yes ☐ No

Signature _____ Date: _____

Reviewed by Provider _____ Date: _____