Pacific Crest Adult Health History – Page 1 of 2

Name: _____ **Date:**

Your answers on this form will help your provider better understand your medical concerns and conditions better. This form will NOT be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you!**

AGE: _____ **How would you rate your general health?** ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Main reason for today's visit: _____

Other concerns I would like to discuss if there is time: _____

REVIEW OF SYMPTOMS: Please check(√) any CURRENT symptoms you have:

Constitutional ☐ Fevers/Sweats/Weakness ☐ Unexplained Weight Loss/Gain

Eyes ☐ Changes in Vision

ENT/mouth ☐ Difficulty Hearing/Ringing in Ears ☐ Hay fever/Allergies

Cardiovascular ☐ Chest pain/discomfort ☐ Palpitations

Breast ☐ Breast lump/nipple discharge

Respiratory ☐ Cough/Wheeze

Gastrointestinal ☐ Blood in Bowel Movement ☐ Nausea/Vomiting/Diarrhea

Genitourinary ☐ Nighttime Urination ☐ Leaking Urine ☐ Unusual Vaginal Bleeding ☐ Discharge:penis or vagina

Musculoskeletal ☐ Muscle/joint pain

Neurological ☐ Headaches ☐ Memory Loss

Psychiatric ☐ Anxiety/stress ☐ Sleep Problem ☐ Depression

Blood/Lymphatic ☐ Unexplained Lumps ☐ Easy bruising/bleeding

Other ☐ Concern with sexual function

Skin ☐ Rash/new or change in mole

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? ☐ Yes ☐ No

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication Name	Dose (mg/pill)	How many times per day?

ALLERGIES or REACTIONS to MEDICINES: _____

Date of your most recent **IMMUNIZATIONS:**

Hepatitis A _____ Hepatitis B _____ Influenza (flu shot) _____ Pneumovax (pneumonia) _____

Tetanus (Td) _____ Zostivax (shingles) _____ Varicella (chicken pox) shot or illness _____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) ☐ Date _____ Abnormal? ☐ Yes ☐ No

Sigmoidoscopy ☐ or Colonoscopy ☐ Date _____ Abnormal? ☐ Yes ☐ No

Women: Mammogram ☐ Date _____ Abnormal? ☐ Yes ☐ No

Women: Pap Smear ☐ Date _____ Abnormal? ☐ Yes ☐ No

Men: PSA (prostate) ☐ Date _____ Abnormal? ☐ Yes ☐ No

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems:

☐ Heart Disease *Specify:* _____ ☐ High Blood Pressure ☐ High Cholesterol

☐ Diabetes ☐ Thyroid Problem

☐ Heart Attack When: _____ ☐ Other (specify) _____

WOMEN'S HEALTH HISTORY: # pregnancies _____ # deliveries _____ # abortions _____ # miscarriages _____

Check if you had the following during pregnancy: ☐ preeclampsia ☐ gestational diabetes ☐ hypertension in pregnancy

1st day of most recent period: _____

Pacific Crest Adult Health History – Page 2 of 2

SURGICAL HISTORY: Please list all prior operations (with dates):

FAMILY HISTORY: Please indicate the current status of your immediate family members with a check(√)

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Problem	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer, Breast	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer, Melanoma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer, Ovary	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer, Colon	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Attack/Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes: on insulin shots	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes. not on insulin	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hearing Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Immune Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Death before age 56 for reason not listed above	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

Cigarettes ☐ Never ☐ Quit Date _____
Current Smoker ☐ packs/day _____ # of years _____
Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
Are you interested in quitting? ☐ No ☐ Yes

Alcohol Use

Do you drink alcohol? ☐ No ☐ Yes # of drinks/week _____
Is your alcohol use a concern for you or others? ☐ No ☐ Yes

Drug Use

Do you use recreational drugs? ☐ No ☐ Yes
Have you ever used needles to inject drugs? ☐ No ☐ Yes

Sexual Activity

Sexually Acitve: ☐ No ☐ Yes ☐ Not currently
Current Sex Partner(s) is/are: ☐ male ☐ female
Birth control method:
Have you ever had any sexually transmitted diseases (STDs)?
☐ No ☐ Yes
Are you interested in being screened for sexually transmitted diseases?
☐ No ☐ Yes

OTHER CONCERNS

Caffeine Intake: ☐ None ☐ Coffee/tea/soda _____ cups/day
Weight: Are you satisfied with your weight? ☐ No ☐ Yes
Diet: How do you rate your diet? ☐ Good ☐ Fair ☐ Poor
Exercise: Do you exercise regularly? ☐ No ☐ Yes
What kind of exercise? _____
How long (minutes) _____ How often? _____
If you do not exercise, why? _____
Safety: Do you use a bike helmet? ☐ No ☐ Yes ☐ NA
Do you use seatbelts consistently? ☐ No ☐ Yes
Is VIOLENCE at home a concern for you? ☐ No ☐ Yes
Have you ever been ABUSED? ☐ No ☐ Yes
Do you have a GUN in your home? ☐ No ☐ Yes

SOCIOECONOMICS

Occupation: _____
Religious Preference: _____
Marital Status: ☐ single ☐ partner/married ☐ divorced ☐ widowed
Spouse/partner's name: _____
Who lives at home with you? _____
Number of children/ages: _____