ADULT PATIENT HEALTH HISTORY

We appreciate you taking the time to complete this form. All information is confidential. This form will be kept in your file. Please Print.

Chief Health Concerns

What are your health concerns at this time?

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Medical History

How would you describe your general state of health? Excellent Good Fair Poor

Have you had any serious conditions, illnesses, injuries, and/or hospitalizations in the past?

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____

Do you have any allergies (medicines, environmental, foods)?

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____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics), with dosage:

____

____

Please list any past prescription medications:

____

____

Approximately how many times have you been treated with antibiotics? _______________

Do you get regular screening visits done by another physician? (Pap, blood tests) Y N

If yes, may we contact the physician to get a copy of those tests? Y N

Doctors Name: ______________________________ Telephone: ___________________________

Do you frequently use any of the following?

- ☐ Laxatives
- ☐ Diet Pills
- ☐ Antacids
- ☐ Aspirin/Tylenol/Advil
- ☐ Caffeine - form and amount/day ____
- ☐ Alcohol - how much/day or week ____
- ☐ Recreational Drugs - what and how much __________________________________

Please indicate what immunizations you have had:

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Hepatitis A
- ☐ "Flu"
- ☐ MMR (measles, mumps, rubella)
- ☐ Smallpox
- ☐ Haemophilus influenza B
- ☐ Tetanus booster
- ☐ Hepatitus B
- ☐ Polio
- ☐ Smallpox

Please indicate any adverse reactions you may have had to past immunizations:

____

Diet

Do you have food allergies or intolerances? Y N Please List:

____

____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

____

How many times a day do you eat the following:

Wheat (breads, pastas, etc.) ____

Dairy (milk, cheese, yoghurt, etc.) ____

Eggs ____

Soy ____

Family Health History

Indicate if a close relative (parent, grandparent, sibling) has had any of the following:

Allergies	Endometriosis	Osteoporosis
Artificial Heart Valve	Gallstones	PMS
Arthritis	Heart Disease	Rubella
Asthma	High Blood Pressure	Rheumatic Fever
Cancer (type_____________)	Kidney Disease	Skin Disease
Diabetes	Mental Illness	Stroke
Eczema	Multiple Sclerosis	Tuberculosis

Any other medical conditions: ____

Environment

Occupation ____

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)?
Please Describe:
____

How would you describe the emotional climate of your home?

____

How stressful is your work, or other aspects of your life?

____

Is there anything that you feel is important that hasn't been covered?

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