

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?

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?

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

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
- Hepatitis 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?
