PRIMARY HEALTH SOLUTIONS
HEALTH HISTORY - ADULT

DATE COMPLETED: ______________________ **PATIENT NAME:** ______________________________

Date of Birth: ______________________________

Please complete this form to help us give you the best possible care

Check conditions below that YOU have now or have had in the past.

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

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
- ☐ Cancer – type:
- ☐ Depression
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Lung disease (emphysema/TB)
- ☐ Stroke
- ☐ Diabetes

NUTRITION

Special diet: ________________________________

Significant weight change in the past 6 months?

☐ No ☐ Yes - ________ lbs. ☐ gain ☐ loss

Do you get enough to eat? ☐ Yes ☐ *No*

Do you have problems with chewing or swallowing?

☐ No ☐ *Yes - describe:*______________________________

Allergies:

Current Medications: *Include prescription, vitamins and over the counter / herbal preparations.*

	Last Tetanus

WOMEN's Health: First menstrual period – Age:_____

Last menstrual period – date: ____/____/____

☐ Menopause – year: __________

OB History: Pregnancies:_____ Living Children:_______

Miscarriages/ Abortions:__________

Birth control: ☐ none ☐ pills Other: ___________________

Last mammogram:___________ ☐ Normal ☐ Abnormal

Do you perform ***Breast Self Exam?*** ☐ Yes ☐ No

Last pap smear: ____________ ☐ Normal ☐ Abnormal

MEN's Health: Last prostate exam: ___________

Do you perform ***Self Testicular Exams?*** ☐ Yes ☐ No

Relationship status: ☐ Single ☐ Spouse/partner ☐ Widowed

Education (last grade/degree completed): ___________________

Your occupation: ______________________________

Do you feel physically and emotionally safe in your relationship and your home? ☐ Yes ☐ *No*

Do you have financial concerns? ☐ No ☐ *Yes*

Do you exercise? ☐ No ☐ Yes – activity: ________________

How often? ___________________

Alcohol ☐ No ☐ Yes type: ___________ frequency:_______

Drugs ☐ No ☐ Yes type: ___________ frequency:_______

Tobacco ☐ No ☐ Yes # per day:_______ since:___________

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

Last exam	Provider	month/year
Medical		
Dental		
Eye		
Hearing		
Colon Screening		

Completed by: ______________________________ ☐ Patient Other: ______________________________

Nurse Review: ______________________________ **Provider review:** ______________________________