MultiCare

ADULT HEALTH HISTORY

(PLEASE PRINT)

TODAY'S DATE: ____________________

NAME: ________________________________
LAST FIRST MIDDLE INITIAL

TYPE OF WORK: ____________________

DATE OF BIRTH: ________________ AGE: ______

MARITAL STATUS: __________ RELIGION: ____________

ADDRESS: ________________ PHONE: __________

EDUCATION: ________________________________
GRADE HIGH SCHOOL VOC. COLLEGE

PREVIOUS M.D.: ____________________

PRESENTLY ACTIVE HEALTH PROBLEMS:

____

____

PAST HEALTH HISTORY (GIVE NAMES & DATES):
PREVIOUS SURGERY:

____

____

PREVIOUS HOSPTIALIZATION/MAJOR ILLNESSES:

____

____

MEDICINES (LIST ALL MEDICINES FREQUENTLY OR PRESENTLY USED: INCLUDE ASPIRIN, VITAMINS & BIRTH CONTROL PILLS)

__________ __________ __________ __________

__________ __________ __________ __________

__________ __________ __________ __________

ALLERGIES OR DRUG REACTIONS:

__________ __________ __________ __________

FAMILY HISTORY	AGE IF LIVING	AGE AT DEATH	PRESENT CONDITION OR CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS			
NUMBER ______			
SISTERS			
NUMBER ______			
CHILDREN:			
BOYS ______			
GIRLS ______			

CHECK IF ANY RELATIVES HAVE HAD:		RELATIONSHIP
DIABETES	❑	______
HEART TROUBLE	❑	______
HEART ATTACK	❑	______
HIGH BLOOD PRESSURE	❑	______
STROKE	❑	______
TUBERCULOSIS	❑	______
ULCERS	❑	______
ARTHRITIS	❑	______
OBESITY (OVER WEIGHT)	❑	______
SUICIDE	❑	______
MENTAL ILLNESS	❑	______
THYROID TROUBLE	❑	______
CANCER	❑	______

NUMBER LIVING IN YOUR HOUSEHOLD: __________

SMOKING

PACKS PER DAY ______________

NO. OF YEARS ______________

YEAR STOPPED ______________

❑ PIPE ❑ CIGAR ❑ CHEW

ALCOHOL

❑ NEVER ❑ OCCASIONAL

❑ MODERATE ❑ HEAVY

ALCOHOL PROBLEM:

❑ YES ❑ NO

COFFEE

CUPS PER DAY ______________

ASPIRIN

TABS PER DAY ______________

PRESENT WEIGHT: __________ USUAL WEIGHT: __________ WEIGHT AT AGE 20: __________

WEIGHT CHANGE LAST YEAR: GAINED: ______ LBS. LOST ______ LBS. HEIGHT: __________

REVIEWED BY:__________PROVIDER'S INITIALS

(PLEASE FILL OUT REVERSE SIDE)

SYSTEM REVIEW: CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR FINDINGS TO AN UNUSUAL OR SIGNIFICANT DEGREE:

HEAD — FREQUENCY

- HEADACHE ❑ ________
- FAINTING ❑ ________
- DIZZINESS ❑ ________
- SEIZURE ❑ ________
- EAR TROUBLE ❑ ________
- SINUS TROUBLE ❑ ________
- STUFFY NOSE ❑ ________
- NOSE BLEEDS ❑ ________
- ALLERGY ❑ ________
- HOARSENESS ❑ ________
- TROUBLE SLEEPING ❑ ________
- TROUBLE HEARING ❑ ________

PULMONARY

- COUGH ❑ ________
- WHEEZING ❑ ________
- PLEURISY ❑ ________
- PNEUMONIA ❑ ________
- TUBERCULOSIS ❑ ________
- SHORTNESS OF BREATH ❑ ________
- NIGHT SWEATS ❑ ________
- CHEST PAIN ❑ ________
- COUGHED UP BLOOD ❑ ________
- ASTHMA ❑ ________

G.I. — FREQUENCY

- TROUBLE SWALLOWING ❑ ________
- LOSS OF APPETITE ❑ ________
- INDIGESTION ❑ ________
- HEART BURN ❑ ________
- NERVOUS STOMACH ❑ ________
- ULCERS ❑ ________
- VOMITING BLOOD ❑ ________
- PASSING BLOOD ❑ ________
- DARK (BLACK) STOOLS ❑ ________
- ABDOMINAL PAIN ❑ ________
- COLITIS ❑ ________
- DIARRHEA ❑ ________
- CONSTIPATION ❑ ________
- HEMORRHOIDS ❑ ________
- CHANGE IN BOWEL HABITS ❑ ________
- GALL BLADDER TROUBLE ❑ ________
- YELLOW JAUNDICE (HEPATITIS) ❑ ________
- LIVER DISEASE ❑ ________

INTEGUMENT

- ANEMIA ❑ ________
- BLOOD DISORDER ❑ ________
- SKIN TROUBLE ❑ ________
- TUMOR OR SWELLING ❑ ________

HEART — FREQUENCY

- HEART TROUBLE ❑ ________
- HEART MURMUR ❑ ________
- RHEUMATIC FEVER ❑ ________
- PALPITATION ❑ ________
- IRREGULAR HEART BEAT ❑ ________
- TIRE EASILY ❑ ________
- ANGINA ❑ ________
- ENLARGED HEART ❑ ________
- HIGH BLOOD PRESSURE ❑ ________
- ANKLE SWELLING ❑ ________

MUS. SKEL

- ARTHRITIS ❑ ________
- BACK PAIN ❑ ________
- BURSITIS ❑ ________
- MUSCLE CRAMPS ❑ ________
- NUMBNESS ❑ ________
- VARICOSE VEINS ❑ ________
- PHLEBITIS ❑ ________

LAB

- ABNROMAL ELECTRO-CARDIOGRAM (EKG) ❑ ________
- ABNORMAL X-RAY ❑ ________
- HIGH BLOOD SUGAR ❑ ________
- LOW BLOOD SUGAR ❑ ________

ENDOCRINE — FREQUENCY

- DIABETES ❑ ________
- HYPOGLYCEMIA ❑ ________
- THYROID TROUBLE ❑ ________
- GOITER ❑ ________
- HOT FLASHES ❑ ________
- FLUID RETENTION ❑ ________
- WEAKNESS ❑ ________
- NERVOUS ❑ ________
- IRRITABLE ❑ ________
- DEPRESSED ❑ ________
- TIRED ❑ ________
- TROUBLE SLEEPING ❑ ________

G/U

- KIDNEY TROUBLE ❑ ________
- URINE INFECTION ❑ ________
- DIFFICULTY URINATING ❑ ________
- PROSTATE TROUBLE ❑ ________
- SUGAR IN URINE ❑ ________
- BLOOD IN URINE ❑ ________
- INFERTILITY ❑ ________
- IMPOTENCE ❑ ________
- FRIGIDITY ❑ ________
- OTHER ❑ ________

ACTIVITY: (CHECK ONE OR MORE BOXES)

I. SEDENTARY LIFE WITH LITTLE EXERCISE ❑

II. MILD EXERCISE WITH JOB, HOUSE OR RECREATION (CLIMB STARS, WALK OVER 3 BLOCKS, GOLF, BOWL, ETC. ❑

III. OCCASIONAL VIGOROUS ACTIVITY WITH WORK OR RECREATION ❑

IV. REGULAR VIGOROUS EXERCISE PROGRAM OR HARD WORK ❑

FEMALES ONLY:

DATE LAST MENSTRUATED: ________

PERIOD EVERY ________ DAYS

ANY MENSTRUAL PROBLEMS?

HEAVY PERIODS ________

INFREQUENT PERIODS ________

SPOTTING ________

IRREGULAR PERIODS ________

PAINFUL PERIODS ________

DISCHARGE ________

NUMBER OF PREGNANCIES ________ NUMBER OF MISCARRIAGES ________ BIRTH CONTROL METHOD (IF ANY) ________ DATE OF LAST PAP SMEAR ________

CHECK IF YOU HAVE HAD:

❑ D&C ❑ HYSTERECTOMY ❑ TOXEIMA ❑ CESAREAN SEC. ❑ DIFFICULTY WITH PREGNANCY ❑ WITH LABOR ❑ WITH DELIVERY

FOR COMPLETE PHYSICAL:

DATE OF LAST COMPLETE PHYSICAL ________

REASON FOR PRESENT EXAMINATION: ________

____

________ FORM FILLED OUT BY

________ SIGNATURE

REVIEWED BY:________PROVIDER'S INITIALS