Hamilton Community Health Network

MEDICAL ADULT HEALTH HISTORY

Date: _____

1. PATIENT'S NAME _____ SOCIAL SECURITY NO. _____/_____/_____

2. HOW IS YOUR HEALTH: _____ GOOD _____ FAIR _____ POOR

3. DO YOU HAVE HEALTH PROBLEMS, CONCERNS? _____ NO _____ YES IF "YES" EXPLAIN:_____

_____

4. ARE YOU BEING TREATED BY A DOCTOR? _____ NO _____ YES IF "YES" DOCTOR'S NAME/ADDRESS:

_____

5. GIVE DATE AND PLACE OF YOUR LAST PHYSICAL EXAM: _____

CHECK "YES" OR "NO" FOR THE FOLLOWING QUESTIONS

	YES	NO		YES	NO
6. ALWAYS HUNGRY	_____	_____	25. FAINTING SPELLS	_____	_____
7. ALWAYS THIRSTY	_____	_____	26. FREQUENT INDIGESTION	_____	_____
8. ALWAYS TIRED	_____	_____	27. FREQUENT NAUSEA	_____	_____
9. ASTHMA	_____	_____	28. FREQUENT VOMITTING	_____	_____
10. BLACK-OUT PERIODS	_____	_____	29. FREQUENT COUGH	_____	_____
11. BLEEDING GUMS	_____	_____	30. GENITALS (SORE OR PAINFUL)	_____	_____
12. BLOOD IN STOOL	_____	_____	31. HEADACHES (FREQUENT/SEVERE)	_____	_____
13. BLOOD PRESSURE PROBLEMS	_____	_____	32. HEART TROUBLE	_____	_____
14. CANCER	_____	_____	33. LOW BLOOD SUGAR	_____	_____
15. COUGH UP BLOOD	_____	_____	34. LOST OR GAINED WEIGHT	_____	_____
16. BLOOD SUGAR PROBLEMS	_____	_____	35. NUMBNESS IN BODY	_____	_____
17. DIARRHEA PROBLEMS	_____	_____	36. PAINFUL URINATION	_____	_____
18. DIFFICULTY HEARING	_____	_____	37. SKIN RASH OR DISEASE	_____	_____
19. DIFFICULTY READING	_____	_____	38. SORE THROAT	_____	_____
20. DIFFICULTY SEEING	_____	_____	39. SICKLE CELL ANEMIA	_____	_____
21. DIFFICULTY SPEAKING	_____	_____	40. STOMACH ULCERS	_____	_____
22. EPILEPTIC/SEIZURES	_____	_____	41. SWOLLEN GLANDS	_____	_____
23. DENTAL PROBLEMS	_____	_____	42. FREQUENT URINATION	_____	_____
24. UNUSUAL DISCHARGE	_____	_____	43. YELLOW SKIN (JAUNDICE)	_____	_____

44. DO YOU USE TOBACCO PRODUCTS? _____ NO ___ YES WHAT? _____HOW MUCH? _____

45. DO YOU USE ALCOHOLIC BEVERAGES? _____ NO ____ YES WHAT? _____HOW MUCH? _____

46. DO YOU HAVE ALLERGIES _____ NO _____ YES EXPLAIN: _____

47. ARE YOU ALLERGIC TO ANY MEDICATION? _____ NO _____ YES EXPLAIN: _____

ARE YOU TAKING ANY NON-PRESCRIBED MEDICATION? _____ NO _____ YES EXPLAIN: _____

_____

ARE YOU TAKING ANY PRESCRIPTION MEDICATION? _____ NO _____ YES

EXPLAIN:_____

48. EVER USED ANTABUSE, TREXAN, OR SYMMETREL FOR ALCOHOL OR DRUG ADDITION? _____ NO _____YES
WHEN: _____

49. HAVE YOU EVER HAD: TUBERCULOSIS? ____ NO _____YES WHERE WERE YOU TREATED AND WHEN?

_____

HEPATITIS _____NO _____ YES WHERE WERE YOU TREATED AND WHEN?

_____

SYPHILIS? _____NO _____ YES WHERE WERE YOU TREATED AND WHEN?

_____

GONORRHEA? _____NO _____YES WHERE WERE YOU TREATED AND WHEN?

_____

CHLAMYDIA? _____NO _____ YES WHERE WERE YOU TREATED AND WHEN?

_____

TO BE COMPLETED BY WOMEN ONLY:

50. AT WHAT AGE DID YOU START HAVING PERIODS? _____ HOW MANY DAYS DO YOU FLOW? _____
51. DATE OF LAST MENSTRUAL PERIOD: _____/_____/_____

		YES	NO
52. DURING YOUR MENSTRUAL CYCLE DO YOU:	HAVE SEVERE CRAMPING?	_____	_____
	UNUSUAL EMOTIONAL UPSET	_____	_____
	BREAST USUALLY SORE	_____	_____
53. HAVE YOU NOTICED ANY LUMPS IN YOUR BREASTS?		_____	_____
54. ARE YOU PREGNANT?		_____	_____
55. ANY DISCHARGE FROM YOUR VAGINA?		_____	_____
56. HAVE YOU EVER CARRIED A CHILD TO FULL TERM?		_____	_____
57. HAVE YOU HAD PROBLEMS WITH MISCARRIAGES?		_____	_____

58. ARE YOU CURRENTLY SEXUALLY ACTIVE _____NO _____YES IF YES, WHAT ARE YOU USING FOR BIRTH CONTROL? _____
59. HAVE YOU EVER HAD AN ABNORMAL PAP? _____NO _____YES IF YES, WHEN? _____
60. ANY SPECIAL PROBLEMS OR CONCERNS? IF SO, PLEASE LIST:

_____

_____

_____

_____

_____

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