ADULT HEALTH HISTORY

NAME _____

DATE OF BIRTH _____ **GENDER M** ☐ **F** ☐

What are your goals for your health?

Current Concerns

1._____

2._____

3._____

Other Healthcare Practitioners

1._____

2._____

Past Medical Diagnoses, surgeries, hospitalizations

1._____

2._____

3._____

Date of last: Physical exam _____

Lab tests _____

Dental visit _____

Last tetanus shot _____

OTHER MEDICAL HISTORY AND REVIEW OF SYSTEMS

GENERAL
- ☐ Fatigue
- ☐ Weight change
- ☐ Difficulty losing wt
- ☐ Fever
- ☐ Night sweats
- ☐ Headache
- ☐ Eating disorder
- ☐ Addiction
- ☐ Slow healing
- ☐ Fainting/ dizziness
- ☐ Insomnia

SKIN
- ☐ Rash
- ☐ Itching
- ☐ Dryness
- ☐ Color changes
- ☐ Moles
- ☐ Excessive sweat
- ☐ Hair loss
- ☐ Heavy body hair
- ☐ Ridges in nails
- ☐ White spot on nails

EENT
- ☐ Eye pain
- ☐ Eye discharge
- ☐ Vision changes
- ☐ Glasses/ contacts
- ☐ Double vision
- ☐ Glaucoma
- ☐ Cataract
- ☐ Ear infections
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Post nasal drip
- ☐ Sinus congestion
- ☐ Hay fever
- ☐ Bloody nose
- ☐ Cold sores
- ☐ Canker sores
- ☐ Bleeding gums
- ☐ Sore throat
- ☐ Bad breath
- ☐ Difficult to swallow

LUNGS
- ☐ Cough
- ☐ Wheezing
- ☐ Short of breath
- ☐ Asthma
- ☐ Bronchitis
- ☐ Painful breathing

HEART
- ☐ Heart murmur
- ☐ Palpitations
- ☐ Chest pain
- ☐ Swelling
- ☐ Anemia

GASTROINTESTINAL
- ☐ Heartburn/ reflux
- ☐ Vomit blood
- ☐ Stomach pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Blood in stool
- ☐ Leaking stool
- ☐ Black stools
- ☐ Abdominal pain
- ☐ Change in stool
- ☐ Gall stones
- ☐ Hernia
- ☐ Low blood sugar

URINARY
- ☐ Painful urination
- ☐ Weak urine stream
- ☐ Blood in urine
- ☐ Kidney infections
- ☐ Nighttime urination
- ☐ Leaking urine
- ☐ Bladder infection

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Joint deformity
- ☐ Muscle tension
- ☐ Back pain

NEUROLOGICAL
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Loss of balance
- ☐ Loss of smell/ taste
- ☐ Seizure
- ☐ Shooting pains

MIND
- ☐ Difficulty coping
- ☐ Excessive stress
- ☐ Depressed
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Forgetful
- ☐ Poor concentration
- ☐ Bad dreams
- ☐ Bipolar disorder
- ☐ Negative thoughts - persistent

MEN ONLY
- ☐ Penile discharge
- ☐ Erectile dysfunction
- ☐ Prostate problems
- ☐ Testicular pain
- ☐ Lump on testicle

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid disorder
- ☐ Too hot or cold
- ☐ Nipple discharge
- ☐ PMS (women)
- ☐ Always thirsty

SEXUALITY
- ☐ Low libido
- ☐ History STD
- ☐ Pain during sex
- ☐ Difficult to orgasm
- ☐ Sexual abuse

OTHER
- ☐ Hospitalized
- ☐ Surgery
- ☐ Blood transfusion

WOMEN ONLY

GYN HISTORY

Age at first period? _____

How often do you have a period? _____

How many days do you bleed? _____

Have you ever had a breast lump? _____

PREGNANCY HISTORY

☐ YES ☐ NO Have you ever been pregnant?

Abortions: ___ miscarriages? ____ adoptions ____

Date of Births:

1. _____

2. _____

3. _____

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6300 9TH Ave NE Suite 300, Seattle, WA 98115
ph. 206.363.5555 fax 206.363.5533

FOUNDATIONS OF WELLNESS

Describe your diet:

_____

_____

Describe your sleep:

_____

_____

Number of servings per day:

_____ Meat
_____ Fish
_____ Dairy
_____ Fruit
_____ Vegetables
_____ Whole grains
_____ Eggs
_____ Sweets/soda

Do you spend time outdoors regularly? ☐ YES ☐ NO
How much do you weigh now? _____
Weight at age 20 _____
How often do you have a bowel movement? _____
Do you sweat easily? ☐ YES ☐ NO

SOCIAL HISTORY

Who do you turn to for support? _____
Who lives in your home? _____
What causes stress for you? _____
What is your occupation? _____

☐ YES ☐ NO Is your home a sanctuary for you?
☐ YES ☐ NO Do you take vacations?
☐ YES ☐ NO Have you experienced domestic violence?

Habits:	Daily	Weekly	Monthly	Rarely or NO
Alcohol	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Toxic exposures through work or hobbies	☐	☐	☐	☐

FAMILY HISTORY

☐ High blood pressure _____
☐ Tuberculosis _____
☐ Heart disease _____
☐ Thyroid disorder _____
☐ Diabetes_____
☐ Stroke _____
☐ Kidney Disease _____
☐ Arthritis _____
☐ Allergy _____
☐ Cancer _____
☐ Obesity _____
☐ Autoimmune disease _____
☐ Epilepsy _____
☐ Substance Abuse _____
☐ Osteoporosis_____
☐ Other _____

MEDICATIONS

Current Prescription Medications
1._____
2._____
3._____

Current Over the Counter Medications
1._____
2._____

Current vitamins, herbs, homeopathics…
1._____
2._____
3._____

Have you had a tetanus booster in the last 10 years? ☐ YES ☐NO

ALLERGIES:

☐ Drug _____
☐ Environmental _____
☐ Food_____

JOY

What practices or activities do you use to sustain your health and well being? (spiritual, religious, inspirational?)

Reviewed by _____ Date _____

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