Premier Health & Wellness

Name_____

Date of Birth_____

Date_____

Adult Health History for New Patients.

PAST MEDICAL HISTORY

Please indicate if you have or have a history of any of the following conditions:

Condition	✓	***Condition***	✓	***Condition***	✓
Abnormal Skin Moles		Coronary Artery Disease		Kidney Stone	
Alcohol/Drug Abuse		Depression		Liver Disease	
Allergy (Hay Fever)		Diabetes (adult onset)		Migraine Headaches	
Anemia		Diabetes (childhood onset)		Osteoporosis	
Anxiety		Diverticulosis		Pneumonia – Year _____	
Arthritis (RA/OA)		Eczema		Prostate (enlarged)	
Asthma		Endometriosis		Prostate (nodules)	
Bipolar Disorder		Emphysema (COPD)		Psoriasis	
Bladder Problems		Fibroid Tumors		Schizophrenia	
Blood clot (leg/lung)		Fracture - _____		Seizure/Epilepsy	
Blood Transfusion		Gallbladder Disease		Shingles	
Breast lump (benign)		Glaucoma		Sleep Apnea	
Cancer - Breast		Gout		Stomach Ulcer	
Cancer - Colon		Heart Attack		Stroke	
Cancer - Ovarian		Heartburn/GERD		Thyroid Nodule	
Cancer - Prostate		Hepatitis – Type _____		Hyperthyroidism - overactive	
Cancer - Lung		High Blood Pressure		Hypothyroidism - underactive	
Cancer-_____		High Cholesterol		Cataracts	
Chicken Pox		Irritable Bowel Syndrome		HIV/AIDS	
Colon Polyp		Kidney Disease/Failure		Other -	

SURGERIES/HOSPITALIZATIONS

Type of surgery or reason for hospitalization	**Date**	**Type of surgery or reason for hospitalization**	**Date**
1.		**4.**	
2.		**5.**	
3.		**6.**	

MEDICATIONS: Please Include Vitamins and Herbs

Medication	Dose	How Often

Premier Health & Wellness

Name_____

Date of Birth_____

Date_____

FAMILY HISTORY- Please indicate any family members who have had the following

Alcohol/Drug Abuse:	High Blood pressure:
Anxiety	High Cholesterol:
Arthritis	HIV/AIDS:
Bipolar disorder:	Osteoporosis:
Cancer – Breast:	Dementia:
Cancer – Colon:	Depression:
Cancer – Ovarian:	Diabetes:
Cancer – Prostate:	Schizophrenia:
Cancer – Skin:	Stroke:
Cancer – other:	Thyroid disease:
Clotting or Bleeding disorder:	Other:
Heart disease:	Other:

List all Healthcare Providers you are currently seeing: _____

_____

ALLERGIES

Please list any medication to which you have had an allergic reaction**, including the type of reaction.**

_____

_____

_____

HEALTH MAINTENANCE & PREVENTION

Lipid (cholesterol) Date _____ Result _____

Colonoscopy Date _____ Result _____

Bone Density Date _____ Result _____

Prostate exam (men only) Date _____ Result _____

Women only:

Mammogram Date _____ Result _____

Pap Smear Date _____ Result _____

IMMUNIZATION: Date of Last Vaccination.

Tetanus(Td)_____Tetanus w/Pertussis(Tdap)_____

Pneumovax(pneumonia)_____Zostavax(shingles)_____

SOCIAL HISTORY:

Marital status (circle one): single partner married divorced widowed

Premier Health & Wellness

Name_____

Date of Birth_____

Date_____

Spouse/partner's name_____

Number of children:_____ Years they were born_____

Who lives at homes with you?_____

Leisure activities, group involvement, religion, volunteer, recent travel: _____

_____

Tobacco Use

History of smoking cigarettes? ☐ Yes ☐ No

If yes, but have quit. Quit date; _____

How many years did you smoke? _____

Current Smoker: packs/day: _____

What age did you start?_____

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use

Do you drink alcohol? ☐ Yes ☐ No

# of drinks/week:_____☐ Wine ☐ Beer ☐ Liquor

Drug Use

Do you use marijuana or recreational drugs?

☐ Yes ☐ No

Have you ever used needles to inject drugs?

☐ Yes ☐ No

Sexual Activity

Currently sexually involved? ☐ Yes ☐ No

Preference: ☐ Male ☐ Female ☐ Both

Birth control method (select all that apply):

☐ None ☐Condoms ☐Pill ☐IUD

☐Vasectomy ☐ Other_____

Exercise: Do you exercise regularly ☐ Yes ☐No

What kind of exercise? _____

How long (minutes)? _____ How often? _____

Diet: How would you rate your diet?

☐Good ☐Fair ☐Poor

Would you like advice on your diet?

☐ Yes ☐ No

Safety: Do you use a bike helmet?

☐ Don't ride a bike ☐ Yes ☐No

Do you use seatbelts consistently?

☐ Yes ☐ No

Does your home have a working smoke detector?

☐ Yes ☐ No

If you have guns in your home, are they locked up?

☐ Not applicable ☐ Yes ☐ No

Is violence at home a concern for you?

☐Yes ☐No

Have you completed an Advance Directive for Health care (ADHC) or Living will? ☐Yes ☐No

If yes, please circle

WOMENS HEALTH HISTORY:

Total # of pregnancies: _____# of live birth:_____ # of miscarriages_____ # of abortions_____

Age when period 1st period began (menstruation):_____

Age when period ended; if applicable (menopause):_____