This is a fillable PDF form. For full functionality, please download the form and use **Adobe Acrobat Reader** to complete it, save it, then email it to **staff@epitomedical.com** or simply print it out and complete it by hand. This notice will not print.

EPITOMEDICAL.

George Med-Peds Associates, P.C.
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# ADULT HEALTH HISTORY FORM

## OVERALL HISTORY

Patient Name: _____ Age: _____ Today's Date: _____

Your answers to these questions are confidential. They are seen only by healthcare workers.

Have you ever stayed in the hospital or had surgery? ☐ Yes ☐ No If yes, please list below:

| Date: | Reason for hospitalization/surgery: | Date: | Reason for hospitalization/surgery: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list the medicine and what happens:

| Medication & allergic reaction: | Medication & allergic reaction: |
|---|---|
| | |
| | |
| | |

Are you taking any medications? ☐ Yes ☐ No If yes, please list below:

| Medication: | How Often Taken: | Dosage: | Medication: | How Often Taken: | Dosage |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

List all medicines you take without a prescription: aspirin, vitamins, laxatives, cold remedies, etc.:

| Medication: | How Often Taken: | Dosage: | Medication: | How Often Taken: | Dosage |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Do you have an advanced directive? ☐ Yes ☐ No Today's Date: _____ Initial: _____

## VACCINATION HISTORY

Have you had:

Measles or a measles shot?
☐ Yes ☐ No ☐ Not Sure If yes, when? _____

A tetanus shot within 10 years ?
☐ Yes ☐ No ☐ Not Sure If yes, when? _____

German measles or a German measles shot?
☐ Yes ☐ No ☐ Not Sure If yes, when? _____

A flu shot?
☐ Yes ☐ No ☐ Not Sure If yes, when? _____

A pneumonia shot?
☐ Yes ☐ No ☐ Not Sure If yes, when? _____

The shingles shot?
☐ Yes ☐ No ☐ Not Sure If yes, when? _____

Have you ever had any allergic reactions to vaccinations?
☐ Yes ☐ No

If yes, please list vaccination and reaction

| Vaccination Name: | Describe the Allergic Reaction: |
|---|---|
| | |
| | |
| | |
| | |
| | |

## FAMILY HISTORY

Has any **MATERNAL** family member had:

☐ Yes ☐ No Diabetes
☐ Yes ☐ No Heart Attack before age 60
☐ Yes ☐ No High Blood Pressure / Hypertension
☐ Yes ☐ No Stroke
☐ Yes ☐ No Breast Cancer
☐ Yes ☐ No Other Cancer
☐ Yes ☐ No Sickle Cell Anemia
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Other (list): _____

Has any **PATERNAL** family member had:

☐ Yes ☐ No Diabetes
☐ Yes ☐ No Heart Attack before age 60
☐ Yes ☐ No High Blood Pressure / Hypertension
☐ Yes ☐ No Stroke
☐ Yes ☐ No Breast Cancer
☐ Yes ☐ No Other Cancer
☐ Yes ☐ No Sickle Cell Anemia
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Other (list): _____

# ADULT HEALTH HISTORY FORM

## HAVE YOU HAD ANY OF THE FOLLOWING?

☐ Yes ☐ No Diabetes
☐ Yes ☐ No Heart Disease
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No High Blood Pressure / Hypertension
☐ Yes ☐ No Blood Clots (Phlebitis)
☐ Yes ☐ No Stroke
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Cancer
☐ Yes ☐ No HIV+ / ARC / AIDS
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Sickle Cell Disease
☐ Yes ☐ No Depression
☐ Yes ☐ No Treatment by a psychiatrist or mental clinic
☐ Yes ☐ No Ulcer
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Positive Tuberculin skin test
☐ Yes ☐ No Hepatitis A / B / C / D / E
☐ Yes ☐ No Kidney or urine infection
☐ Yes ☐ No Thyroid problems
☐ Yes ☐ No Broken bones
☐ Yes ☐ No High blood fats
☐ Yes ☐ No Venereal disease:
☐ Yes ☐ No Gonorrhea
☐ Yes ☐ No Syphilis
☐ Yes ☐ No Chlamydia
☐ Yes ☐ No Herpes
☐ Yes ☐ No Venereal warts
☐ Yes ☐ No Other illnesses / diagnoses not mentioned above. Please list:

_____

_____

Physician's Notes:

## HEALTH HABITS

☐ Yes ☐ No Do you always wear seatbelts?
☐ Yes ☐ No Do you salt your food at the table?
☐ Yes ☐ No Do you smoke cigarettes?
If yes, how many packs per day? _____
For how long have you smoked? _____
☐ Yes ☐ No Do you use street drugs or marijuana?
☐ Yes ☐ No Do you ever drink alcohol?
How many drinks do you need to get high? _____
☐ Yes ☐ No Have you tried to stop drinking or drinking less?
☐ Yes ☐ No Do you ever drink to wake up in the morning?
☐ Yes ☐ No Do you become irritated when people ask you about your drinking?
☐ Yes ☐ No Do you ever feel badly about your drinking?
When was your last drink of alcohol? _____
☐ Yes ☐ No Have you or any of your sexual partners used IV drugs, such as heroin, cocaine, etc.?
☐ Yes ☐ No Have you or any of your sexual partners received a blood transfusion?
☐ Yes ☐ No Has there been any physical abuse in any of your relationships in the last year?
☐ Yes ☐ No Do you exercise?
If yes, how many times a week? _____
What kind of exercise? _____

Physician's Notes:

# ADULT HEALTH HISTORY FORM

## PERSONAL INFORMATION

☐ Yes ☐ No Are you employed?

What type of work? _____

List any dangers exposed to at work:
(dust, chemicals, radiation, noise, asbestos, etc.)

_____

**SEXUAL HABITS:**

Do you have sex with: ☐ Men ☐ Women ☐ Both

How many sexual
partners do you have? ☐ None ☐ One ☐ More than one

☐ Yes ☐ No Do you have unprotected sex?

Physician's Notes:

## BODY SYSTEM REVIEW

How would you
describe your health? ☐ Good ☐ Fair ☐ Bad

☐ Yes ☐ No In the past six months have you lost or gained more than 10 pounds without trying?

In the past 12 months, have you had:

☐ Yes ☐ No Any skin changes (moles, etc.)
☐ Yes ☐ No Any eye trouble?
☐ Yes ☐ No Poor hearing or other ear problem?
☐ Yes ☐ No A hoarse voice or a chronic cough?
☐ Yes ☐ No Shortness of breath or wheezing when active?
☐ Yes ☐ No Chest Pain?
☐ Yes ☐ No Swelling of your feet and ankles?
☐ Yes ☐ No Leg cramps when walking?
☐ Yes ☐ No Heartburn or stomach pain?
☐ Yes ☐ No Trouble swallowing?
☐ Yes ☐ No Blood in your bowel movement?
☐ Yes ☐ No A recent change in your bowel movements?
☐ Yes ☐ No Trouble with your urine?
☐ Yes ☐ No Bad headaches often?
☐ Yes ☐ No Other symptoms that worry you? Please list:

_____

_____

Physician's Notes:

## FOR MEN ONLY

☐ Yes ☐ No Do you do testicular checks monthly?
☐ Yes ☐ No Have you gotten a prostate exam?
If yes, when was your last exam? _____
☐ Yes ☐ No Do you have any urinary problems?

Physician's Notes:

## FOR WOMEN ONLY

Number of times you have been pregnant: _____
Number of living children: _____
Number of stillborns: _____
Number of miscarriages / abortions: _____

☐ Yes ☐ No Do you have problems with your period?
When was your last period? _____
What was your age at your 1st period? _____

☐ Yes ☐ No Do you have a vaginal discharge?
☐ Yes ☐ No Do you check your breasts monthly?
☐ Yes ☐ No Have you ever had a mammogram (Breast X-Ray)?
If yes, when was your last exam? _____

Physician's Notes:

# ADULT HEALTH HISTORY FORM

## FOR WOMEN ONLY (CONT.)

☐ Yes ☐ No Do you have breast pain, breast lumps, cysts or discharge?

☐ Yes ☐ No If you have gone through menopause (change of life), do you have any spotting or bleeding for your vagina now?

☐ Yes ☐ No Have all of your Pap smears been normal?

When was your last Pap smear? _____

☐ Yes ☐ No Have you ever had an infection in your fallopian tubes?

☐ Yes ☐ No Are you using birth control?

If "yes", list what type? _____

☐ Yes ☐ No Has your mother ever had a miscarriage?

☐ Yes ☐ No If "yes", was she given a medicine to stop it from happening again (example: DES)?

Physician's Notes:

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____