GEORGE MED-PEDS ASSOCIATES, P.C.
PO BOX 82227
LAS VEGAS, NEVADA 89180-2227

ADULT HEALTH HISTORY

PATIENT NAME: _____ **AGE:** _____ **TODAY'S DATE:** ____/____/____

I. Your answers to these questions are confidential. They are seen only by Health Care Workers.

	YES	NO
Have you ever stayed in the hospital / had surgery?	**0**	**0**

If yes, please list below:

Date	Reason for hospitalization / surgery	Date	Reason for hospitalization / surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications

Are you allergic to any medications?	**0**	**0**

If yes, please list the medicine and what happens.

_____ _____
_____ _____
_____ _____

Are you taking any medications?	**0**	**0**

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
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Have you had:	YES	NO	NOT SURE
1. Measles or measles shot ? If yes, when? _____	**0**	**0**	**0**
2. A tetanus shot within 10 years ? If yes, when ? _____	**0**	**0**	**0**
3. German measles or a German measles shot ? If yes, when ? _____	**0**	**0**	**0**
4. Have you ever had a flu shot ? If yes, when ? _____	**0**	**0**	**0**
5. Have you ever had a pneumonia shot ? If yes, when ? _____	**0**	**0**	**0**
6. Have you ever had the shingles shot ? If yes, when ? _____	**0**	**0**	**0**

Have you ever had any allergic reactions to vaccinations?

___ NO

___YES (If yes, please list vaccination and reaction)

VACCINATION	ALLERGIC REACTION
_____	_____
_____	_____

DOES PATIENT HAVE AN ADVANCED DIRECTIVE?
YES _____ **NO** _____ **Date:** _____ **Initials:** _____

II. 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): _____

II. 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): _____

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II. Have you had any of the following?	**Yes**	**No**	**PHYSICIAN NOTES**
Diabetes	O	O	
Heart Disease	O	O	
Rheumatic Fever	O	O	
High Blood Pressure / Hypertension	O	O	
Blood Clots (Phlebitis)	O	O	
Stroke	O	O	
Arthritis	O	O	
Cancer	O	O	
HIV+ / ARC / AIDS	O	O	
Glaucoma	O	O	
Epilepsy (seizures)	O	O	
Sickle Cell Disease	O	O	
Depression	O	O	
Treatment by a psychiatrist or mental clinic	O	O	
Ulcer	O	O	
Asthma	O	O	
Tuberculosis	O	O	
Positive Tuberculin skin test	O	O	
Hepatitis A / B / C / D / E	O	O	
Kidney or urne infection	O	O	
Thyroid problems	O	O	
Broken bones	O	O	
High blood fats	O	O	
Venereal disease:	O	O	
Gonorrhea	O	O	
Syphilis	O	O	
Chlamydia	O	O	
Herpes	O	O	
Venereal Warts	O	O	
List any other illnesses / diagnosis not mentioned above:	O	O	
_____			
_____			

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

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V. Personal Information	**Yes**	**No**	**PHYSICIAN NOTES**
Are you employed?	O	O	
Type of work: _____			
List any dangers exposed to at work: (dust, chemicals, radiation, noise, asbestos, etc.) _____			
Sexual Habits:			
Do you have sex with: O Men O Women O Both			
How many sexual partners do you have? O None O One O More than one			
Do you have unprotected sex?	O	O	

VI. Body System Review	**Yes**	**No**	**PHYSICIAN NOTES**
How would you describe your health? O Good O Fair O Bad			
In the past six months have you lost or gained more than 10 pounds without trying?	O	O	
In the past 12 months, have you had:			
Any skin changes (moles, etc.)	O	O	
Any eye trouble?	O	O	
Poor hearing or other ear problem?	O	O	
A hoarse voice or a chronic cough?	O	O	
Shortness of breath or wheezing when active?	O	O	
Chest Pain?	O	O	
Swelling of your feet and ankles?	O	O	
Leg cramps when walking?	O	O	
Heart burn or stomach pain	O	O	
Trouble swallowing?	O	O	
Blood in your bowel movement?	O	O	
A recent change in your bowel movements?	O	O	
Trouble with your urine?	O	O	
Bad headaches often?	O	O	
Other symptoms that worry you? If "yes", list: _____ _____	O	O	

VII. For Men Only	**Yes**	**No**	**PHYSICIAN NOTES**
Do you do testicular checks monthly?	O	O	
When was your last prostate exam? _____	O	O	
Do you have any urinary problems?	O	O	

VIII. For Women Only	**Yes**	**No**	**PHYSICIAN NOTES**
Number of times pregnant	_____		
Number of living children	_____		
Number of stillborns	_____		
Number of miscarriages / abortions?	_____		
Do you have problems with your period?	O	O	
When was your last period?	_____		
Age at 1st period?	_____		
Do you have a vaginal discharge?	O	O	

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VIII. For Women Only	**Yes**	**No**	**PHYSICIAN NOTES**
Do you check your breasts monthly?	**O**	**O**	
Have you ever had a mammogram (Breast X-Rays)? If "yes", when? _____	**O**	**O**	
Do you have breast pain, breast lumps, cysts or discharge?	**O**	**O**	
If you have gone through menopause (change of life), do you have any spotting or bleeding for your vagina now?	**O**	**O**	
Have all of your Pap smears been normal? When was your last Pap smear? _____	**O**	**O**	
Have you ever had an infection in your fallopian tubes?	**O**	**O**	
Are you using birth control? If "yes", list what type _____	**O**	**O**	
Has your mother ever had a miscarriage? If "yes", was she given a medicine to stop it from ever happening again? (example, DES?)	**O**	**O**	

_____ _____
PATIENT SIGNATURE PROVIDER SIGNATURE

_____ _____
DATE DATE