complete HEALTH™

Adult Health History (Ages 18+)

Today's Date:___________

NAME:	DATE OF BIRTH:

Past Medical History: Check conditions you have or have had in the past

☐ Hypertension (High Blood Pressure)	☐ Heart Attack When: ____________	☐ Congestive Heart Failure	☐ Hyperlipidemia (High Cholesterol)
☐ COPD	☐ Asthma	☐ Other lung disease Specify: ___________	☐ Thyroid Disease Specify: ___________
☐ Stroke When: ___________	☐ Diabetes Type: ___________	☐ Urinary Tract Infections	☐ Prostate Disease Specify: ___________
☐ Kidney Disease Specify: __________	☐ Heartburn/Reflux Ulcers	☐ Hepatitis A, B or C Please circle which?	Other liver disease Specify: ___________
☐ Substance Abuse Which: ___________	☐ Depression	☐ Anxiety	☐ Other Psych disease Which: ____________
☐ Skin Condition Specify: __________	☐ Ear Condition Specify: __________	☐ Eye Disorder Specify: ___________	☐ Arthritis Specify: ____________
☐ Bleeding Disorder Specify:	☐ Blood Transfusion	☐ Anemia	☐ Cancer Specify: ____________
☐ HIV/AIDS	☐ Epilepsy	☐ Dementia/memory problems	☐ Blood Vessel Disease
☐ Other Specify: _________	☐ Other ☐ Specify: _______	☐ Other Specify: ___________	☐ Other Specify: ___________

Do you currently use tobacco? ☐ **Yes** ☐ **No**

How many packs/cigarettes per day? ________________________________

If you chew tobacco, how many cans per week? ______________________________________

Do you drink alcohol? ☐ **Yes** ☐ **No**

If yes, how many drinks per day?____

Please circle. Would you consider yourself a:

Social Drinker Heavy Drinker Never drink alcohol Former alcohol consumer

Do you use any mind altering drugs? ☐ **Yes** ☐ **No** **If yes, please circle.**

Marijuana Cocaine IV Drugs Other:____

Do you drink coffee? **Yes** ☐ **No** ☐ **If yes, how many cups per day?**______________________

Do you drink energy drinks? **Yes** ☐ **No** ☐ **If yes, how many per day?** _________________________

Have you had any prior surgeries? **Yes** ☐ **No** ☐
If yes, please indicate which surgeries you had.

☐ Eye Surgery Specify: ____________	☐ Ear Tubes	☐ Thyroid Surgery	☐ Tonsillectomy
☐ Angioplasty/Stents	☐ Aortic Aneurysm Repair	☐ Open Heart Surgery/Bypass	☐ Pacemaker Placement
☐ Heart Surgery Specify: ___________	☐ Lung Surgery Specify: ___________	☐ Mastectomy	☐ Breast Biopsy
☐ Cholecystectomy (Gall bladder)	☐ Weight loss surgery Which: _____________	☐ Appendectomy	☐ Gastric surgery Specify? __________
☐ Bladder Surgery Specify: ____________	☐ Hernia Repair Specify: ___________	☐ Back Surgery Specify: ___________	☐ Carpal Tunnel Which side? ________
☐ Prostate Surgery Specify: ____________	☐ C-section	☐ Hysterectomy	☐ Ovary or Ovarian Cyst removal
☐ Cervix Treatment: LEEP/Cyro/Laser	☐ Laparoscopy	☐ Kidney Surgery: Specify: ___________	☐ Lithotripsy
☐ Neurosurgery Specify: ___________	☐ Orthopedic Surgery Specify: ____________	☐ Other Specify: ___________	☐ Other Specify: ____________

Is there any family history of any of the following? Please indicate who in immediate family had this: (mom, dad, brother, sister, son, daughter, maternal grandmother, paternal grandmother, maternal grandfather, paternal grandfather)

☐ Alcoholism __________ __________ __________	☐ Mental Illness __________ __________ __________	☐ Diabetes __________ __________ __________	☐ Heart Attack __________ __________ __________	☐ Heart Disease __________ __________ __________	☐ High Blood Pressure __________ __________ __________
☐ Lung Disease __________ __________ __________	☐ Anemia __________ __________ __________	☐ Migraine Headaches __________ __________ __________	☐ Autoimmune Disease __________ __________ __________	☐ Kidney Disease __________ __________ __________	☐ Seizure Disorder __________ __________ __________
☐ Thyroid Disease __________ __________ __________	☐ Skin Cancer __________ __________ __________	☐ Brain Cancer __________ __________ __________	☐ Breast Cancer __________ __________ __________	☐ Cervical Cancer __________ __________ __________	☐ Colon Cancer __________ __________ __________
☐ Testicular Cancer __________ __________ __________	☐ Thyroid Cancer __________ __________ __________	☐ Lung Cancer __________ __________ __________	☐ Ovarian Cancer __________ __________ __________	☐ Prostate Cancer __________ __________ __________	☐ Other Cancer What kind: __________ __________ __________

Males and Females: Have you ever had an STD? If yes, please indicate which one(s)		
☐ Herpes	☐ Chlamydia	☐ Genital Warts
☐ HPV	☐ HIV	☐ Trichomoniasis
☐ Syphilis	☐ Gonorrhea	

Females: Pregnancy History

Have you ever been pregnant?

If yes, how many times? (Gravida): __________

How many times have you given birth? (Para): ________

How many of these were full term? _________

How many of these were premature? _________

How many miscarriages have you had? __________

How many living children do you have? ____________

How many abortions have you had? ___________

Sexuality:

Are you Sexually Active? ☐ Yes ☐ No

What is your Gender? ☐ Female ☐ Female-to-Male/Transgender Male
☐ Male ☐ Male-to-Female/Transgender Female
☐ Other ☐ Choose not to disclose

What is your Sexual Orientation?
☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Something else ☐ Don't know

What is your current marital status?		
☐ Single	☐ Divorced	☐ Legally Separated
☐ Married	☐ Widowed	☐ Do not wish to say

What is your ethnicity?		
☐ Hispanic/Latino	☐ Non-Hispanic/Latino	☐ Do not wish to say

What is your race?		
☐ Asian	☐ Native Hawaiian	☐ Other Pacific Islander
☐ African American	☐ American Indian/Alaskan Native	☐ White
☐ More than one race	☐ Do not wish to say	

Work Status:		
☐ Employed	☐ Disabled	☐ Full Time Student
☐ Self-employed	☐ Retired	☐ Part Time Student
☐ Unemployed	☐ Migrant Worker	☐ Seasonal

Living Situation for Homeless Patients:	
☐ Homeless Shelter	☐ On the Street
☐ Doubling Up	☐ Permanent Supportive Housing
☐ Transitional Housing	☐ Other

Are you a veteran? ☐ **Yes** ☐ **No**

Are you a disabled? ☐ **Yes** ☐ **No**

Do you have an important religious affiliation you wish us to know about: ☐ **Yes** ☐ **No**

Are you currently in a domestic abuse situation? ☐ **Yes** ☐ **No**