**Adult Personal History Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: None Yes (see attached sheet) Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications : None Yes (see attached sheet) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Chronic Problems and Medical Diagnoses:** | **Date of Onset** | **Screening Exams:** | **Date Last Completed:** |
|  |  | Physical |  |
|  |  | Mammogram |  |
|  |  | Pap Smear |  |
|  |  |  Abnormal Pap (if ever) |  |
|  |  | Colonoscopy |  |
|  |  | DRE (digital rectal exam) |  |
| **Hospitalizations/Surgeries/Traumas:** | **Date** | PSA – prostate |  |
|  |  | Osteoporosis |  |
|  |  | Dental |  |
|  |  | Eye |  |
|  |  | TB – tuberculosis |  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **For women: Pregnancies** |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Number of times you’ve been pregnant: |  | **Immunizations:** | **Date:** |
| Of those, how many were 9 month pregnancies? |  | Flu Shot |  |
| How many were less than 9 months but the baby was born alive? |  | Pneumonia vaccination |  |
| Number of miscarriages or abortions: |  | Hepatitis B immunization |  |
| Number of living children: |  | Td – Tetanus vaccine |  |
| Start date of last menstrual period: |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

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| Marital status:  |  Single Married Divorced Widowed Other |
| Do you use herbs, vitamins, supplements, or any over-the-counter medications? |  |
| Do you have any religious or cultural beliefs that may impact your healthcare? |  |
| Education level: |  |
| Occupation: |  |
| Hobbies and Interests: |  |

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| Tobacco |  Non-smoker Ex-smoker Current Smoker Chewing Tobacco |
| Alcohol |  Do not drink Drink this often: \_\_\_\_\_\_\_ times per \_\_\_\_\_\_\_\_\_\_\_\_ |
| Illicit Drugs |  Yes No If yes, which drugs: |
| Do you share needles? |  Yes No |
| Have you ever had an exposure to anything toxic or hazardous either through an employer or through military service? |  |

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| Over the past 2 weeks have you felt down, depressed, or hopeless OR have you had little interest or pleasure? |  Yes No |
| Are you currently or have you ever been in a relationship where you were physically hurt, threatened, or made to feel afraid? |  |
| Have you ever felt pressured or forced to have sex when you didn’t want to? |  |
| Have you ever been in jail or prison? | Yes No If yes, dates and reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| List all of the individuals living in your household: |

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| --- | --- | --- | --- |
| **Name** | **Age** | **Relationship** | **Other** |
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| Are you exposed to household pets on a regular basis? | Yes No If yes, types of pets: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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|  | Yes | No | Other |
| Are there smoke detectors in your home? |  |  |  |
| Do you have a carbon monoxide detector? |  |  |  |
| Has your home ever been tested for radon? |  |  |  |
| Are there firearms in your home? |  |  | If yes, are the firearms secured? |
| Do you have city water? If no, when was the last time you had your well tested? |  |  |  |
| Was the metal plumbing in your home installed before 1978? |  |  |  |

**Family Health History**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Illness** | **Self** | **Mom** | **Dad** | **Siblings** | **Grandmother** | **Grandfather** | **Other** |
| Allergies |  |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  |
| Bleeding |  |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |  |
|  Breast or Ovarian |  |  |  |  |  |  | Aunt |
| CVA – Stroke |  |  |  |  |  |  |  |
| Diabetes Type I |  |  |  |  |  |  |  |
| Diabetes Type II |  |  |  |  |  |  |  |
| DVT/PE blood clots |  |  |  |  |  |  |  |
| Eye disease |  |  |  |  |  |  |  |
| Heart disease |  |  |  |  |  |  |  |
| Hypertension (HTN) |  |  |  |  |  |  |  |
| Immunocompromised (weak immune system) |  |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |  |
| Pulmonary disease |  |  |  |  |  |  |  |
| Seizures |  |  |  |  |  |  |  |
| Skin disease |  |  |  |  |  |  |  |
| Ulcer |  |  |  |  |  |  |  |
| Alcohol abuse |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |
| Drug abuse |  |  |  |  |  |  |  |
| Mental illness |  |  |  |  |  |  |  |
| Neurological disease |  |  |  |  |  |  |  |
| Suicide attempt |  |  |  |  |  |  |  |
| Chicken Pox |  |  |  |  |  |  |  |
| Rheumatic fever / Blood transfusion |  |  |  |  |  |  |  |
| Sexually transmitted diseases |  |  |  |  |  |  |  |
| **Other:** |  |  |  |  |  |  |  |
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M = Maternal (mother’s side of the family)

 P = Paternal (father’s side of the family)

Patient or Responsible Party Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication and Food Allergies**

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| **Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Medication Log**

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| **Pharmacy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Name of Medication** | **How much do you take?** | **How often do you take it?** | **When did you start taking it?** |
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