HUTCHINSON Clinic

ADULT Confidential Health History Form

Name	Date of Birth

Illnesses – please check conditions that you have had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ Heart attack
- ❑ Congestive heart failure
- ❑ Heart valve problem
- ❑ Other heart problem
- ❑ Blood clots – legs
- ❑ Blood clots - lungs
- ❑ Stroke
- ❑ Depression
- ❑ Asthma
- ❑ Emphysema / COPD
- ❑ High cholesterol
- ❑ Pneumonia
- ❑ Thyroid problem
- ❑ Migraine headaches
- ❑ Glaucoma
- ❑ Ulcer ❑ Bleeding ulcer
- ❑ Other stomach problems
- ❑ Polyps in colon
- ❑ Diverticulitis
- ❑ Ulcerative colitis
- ❑ Crohn's disease
- ❑ Pancreatitis
- ❑ Hepatitis
- ❑ Frequent urinary infections
- ❑ Bladder problem
- ❑ Kidney stones
- ❑ Other kidney problem
- ❑ Rheumatoid arthritis
- ❑ Other arthritis
- ❑ Parkinson's disease
- ❑ Multiple sclerosis
- ❑ Cancer – colon/rectum
- ❑ Cancer - breast
- ❑ Cancer - ovaries
- ❑ Cancer – prostate
- ❑ Cancer - lung
- ❑ Cancer – other
- ❑ Blood transfusion
- ❑ HIV infection

Surgeries – please check any of the following surgeries that you've had:

❑ Check here if you have NEVER had ANY surgical procedure in your life

- ❑ Cataracts ❑ right ❑ left
- ❑ Tonsillectomy ❑ and Adenoids
- ❑ Ear / nose / sinus
- ❑ Thyroid
- ❑ Appendectomy
- ❑ Gallbladder
- ❑ Colon or rectal surgery
- ❑ Hernia - ❑ groin ❑ umbilical
- ❑ Knee surgery
- ❑ Hip surgery
- ❑ Shoulder surgery
- ❑ Heart bypass
- ❑ Heart Angioplasty ❑ with stents
- ❑ Chest / lung surgery
- ❑ Carotid surgery / stents
- ❑ Breast surgery
- ❑ Hysterectomy
- ❑ C-section
- ❑ Prostate surgery
- ❑ Vasectomy
- ❑ Back / neck surgery
- ❑ Colonoscopy
- ❑ Gastroscopy (stomach scope)
- ❑ Other (please list)

MEDICATIONS – please bring ALL medication bottles to your appointment – or list ALL medications below including dosages, prescribing physician. If you need more room – continue on back side of sheet

❑ I will bring my medication bottles – so I have not written them below

Name of Medicine	Size (mg)	Number of times you take it per day	Prescribing physician	Reason for medication

Do you use any health foods, herbs, supplements? ❑ no ❑ yes (please list below)

ALLERGIES – please list all medications that you are allergic to, describe the reaction, approximate year of rxn
❑ I have NO medical allergies

FAMILY HISTORY – many medical problems can be inherited from relatives. Please check if you have any relative with the following health problems (parents, brother/sister, children, grandparents, aunt/uncle)

❑ Diabetes	❑ Kidney disease / dialysis	❑ Cancer – ovarian
❑ High blood pressure	❑ Epilepsy/seizures	❑ Cancer - melanoma
❑ High cholesterol	❑ Glaucoma	❑ Blood disease (leukemia, etc.)
❑ Stroke or mini-stroke	❑ Cancer - Colon or rectal	❑ Sickle cell anemia or trait
❑ Heart attack, angioplasty, or stent in man under age 55 or woman under 60	❑ Colon polyps	❑ Tuberculosis
	❑ Cancer - prostate	❑ Alcoholism / drug addition
❑ Aneurysm – brain or aorta	❑ Cancer - breast	

Please indicate the health status of the following relatives, current approx age, list h

Relative	Alive?	Age – current or at death	Health problems – cause of death – any other important information
Paternal grandfather	Y N		
Paternal grandmother	Y N		
Maternal grandfather	Y N		
Maternal grandmother	Y N		
Father	Y N		
Mother	Y N		
Brother/Sister (list name)			
1	Y N		
2	Y N		
3	Y N		
4	Y N		
5	Y N		
6	Y N		

SOCIAL HISTORY – please answer the following questions as completely as possible

Marital status: ❑ never married ❑ single ❑ divorced (# ____) ❑widow/widower ❑ married (name)

Children: #_______ - please indicate names, age or year of birth, health status, city of residence, occupation

#1

#2

#3

#4

#5

#6

#7

#8

Education achieved: ❑ 8th grade ❑ High school ❑ Trade school ❑Assoc degree ❑ BS degree ❑ Post-grad

Current Job: Current Employer:

Previous Jobs:

Tobacco Use: ❑ never ❑ quit in yr _____ - I smoked ____ pks/day for _____ yrs ❑ smoke ____ pks/day for ____yrs
❑ chew tobacco ❑ pipe - # per day ______ ❑ other

Alcohol Use: ❑ never ❑ quit in yr _____ ❑ yes – avg ______ drinks/week -- ❑ beer ❑ wine ❑ hard liquor

Has anyone ever suggested you might have a drinking problem? ❑ no ❑ yes – who?

Ever used drugs (marijuana, cocaine, meth, etc)? ❑ never ❑ quit – when? ❑ current user

Ever been addicted to pain medications? ❑ never ❑ quit – when? ❑ current user

# of each in usual day: Diet soda- Non-diet soda- Coffee- Tea-

Sexual Orientation: ❑ not sexually active ❑ heterosexual ❑ homosexual ❑ bisexual

SYMPTOM REVIEW – please indicate which of the following symptoms you have had a problem with in the last several weeks/months – or any that have been a particular problem.

❑ Headache, new or different
❑ Hearing problem, ringing in ears
❑ Eyes – blurry or double vision
❑ .. blind spots in vision
❑ Nose/sinus – congestion/drainage
❑ Frequent nose bleeds
❑ Throat – sore or drainage
❑ Voice – different or hoarse
❑ Neck pain or stiffness
❑ Neck lumps or tenderness
❑ Problems – teeth, gums, mouth
❑ Frequent / troublesome cough
❑ Cough up blood
❑ Shortness of breath at rest
❑ Shortness of breath with exertion
❑ Shortness of breath while lying down or that wakes from sleep
❑ Painful breathing
❑ Chest tightness, heaviness, or pressure
❑ …. With exertion
❑ Irregular or pounding heart beats
❑ Trouble swallowing, food sticks, or comes back up
❑ Indigestion / belching

❑ Nausea or vomiting
❑ Acid comes up in throat or mouth or burns in throat or stomach
❑ Constipation, diarrhea, or change in bowel habits
❑ BMs that are black, tarry, bloody, or different than usual
❑ Hemorrhoid problems
❑ Bleeding from rectum
❑ Difficult or painful urination
❑ Blood in urine
❑ Pain/swelling in genitals
❑ Ever had venereal disease/STD
❑ Discharge from genitals
Sexually active: ❑ yes ❑ no
❑ Trouble with sex life
❑ (W) problem with periods
Date of last menses? _____________
❑ (W) Method of contraception __________________________
❑ (W) Abnormal pap smear ever
❑ (W) Breast lumps or pain
❑ Pain/swelling in groin

❑ Pain – ❑ hip ❑ knee ❑ feet
❑ Pain - ❑ shoulder ❑ arm ❑ hand
❑ Pain - back
❑ Pain – anywhere else
❑ Swelling in feet or legs
❑ Red, swollen joints
❑ Unexplained weight gain or loss
❑ Poor appetite
❑ Unexplained fever, sweats, chills
❑ Skin rash/sores, abnormal moles or skin lesion
❑ Any new or enlarging lumps in or under the skin
❑ Problem with coordination, balance, frequent falling
❑ Abnormal tingling or numbness
❑ Problem with moods, negative feelings or thoughts
❑ Problem with relationships – family, work, friends
❑ Frequently feels nervous, edgy

PREVENTIVE HEALTH ISSUES

Do you wear seat belts? ❑ never ❑ sometimes ❑ most of time
Do you use sunscreen with prolonged sun exposure? ❑ never ❑ sometimes ❑ most of time
Motorcycle – do you use helmet? ❑ not applicable ❑ never ❑ sometimes ❑ most of time
Exercise? ❑ never/rarely ❑ 1-2 times/wk ❑ 3-4 times/wk ❑ more than 4 times per week
What do you do? For how long?

PREVENTIVE TESTS – please check any of the following you have had – approximate date

❑ Cholesterol check
❑ Stool check for blood
❑ Colonoscopy
❑ PSA (prostate blood test)
❑ Digital rectal exam
❑ Cardiac stress test

❑ Heart catheterization
❑ Blood sugar test
❑ PAP smear
❑ Mammogram
❑ Bone density (DEXA)

IMMUNIZATIONS – please indicate the date of your last immunization for each of these			
Tetanus:	Date	Where given?	❑ never received
Pneumovax:	Date	Where given?	❑ never received
Prevnar:	Date	Where given?	❑ never received
Shingles (Zostavax):	Date	Where given?	❑ never received
Hepatitis B: #1	#2	#3	❑ never received
Other:			

PREVIOUS PHYSICIANS – sometimes it is important to obtain some of your prior medical records. Please provide names and addresses for physicians that you have seen in the last 10 years

OTHER Healthcare Providers – please provide us the names of the following:
Eye doctor:
Dentist:
Pharmacy:
Specialists you are currently seeing:
Cardiology (heart):
Pulmonologist (lung):
Other:

Please list issues/concerns/questions that you wish to discuss with the doctor

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Signature ____ Date ____________________