MISSION EAST DALLAS
FAMILY HEALTH CLINIC

ADULT HEALTH HISTORY

Please complete all sides

Name_____ Date of Birth_____

Age _____ Date _____

(Month/Day/Year)

I. ANSWER THE FOLLOWING		
Yes	No	Questions
		Were you born outside of the USA? Where? _____
		Who was your last primary doctor? _____
		When were you last seen? _____
		Are you currently seeing any specialists? If yes, Who? _____

II. PAST MEDICAL HISTORY: Have you had any of the following? (Check Yes or No):					
Yes	No	Questions	Yes	No	Questions
		Glasses			Anemia
		Other vision problems			Blood clots (lungs or legs)
		Glaucoma			Circulation problems
		Hearing problems			Chickenpox
		Environmental Allergies (dust, pollen, etc)			Tuberculosis (TB) or contact with TB
		Asthma			HIV infection
		COPD or emphysema			Sexually transmitted diseases (STD/STI)
		High blood pressure			Sexual function problems
		High cholesterol			Depression
		Heart disease (heart attack, heart failure)			Anxiety/panic disorder
		Thyroid problem			Suicide attempts
		Diabetes			Nervous system problems
		Stomach or bowel problems			Severe headaches
		Liver problems			Epilepsy (seizures)

		Rectal bleeding			Stroke
		Kidney problems			Arthritis
		Problems with urination or bladder			Back problems
		Cancer			
		Radiation treatment to head/neck			

III. SURGICAL/HOSPITALIZATION HISTORY: (Check Yes or No)

Yes	No	Questions
		Surgery/serious injury/hospitalization. If yes, when? _____ _____ __
		Recent hospitalizations? _____When? _____ Why? _____

IV. FAMILY HISTORY: Include parents, sisters, brothers, aunts, uncles, grandparents (*blood relatives only*). Has any family member had:

Yes	No	Questions	Yes	No	Questions
		Migraines: Who? _____			Birth defects: Who? _____
		Stroke: Who?_____			Breast Cancer: Who? _____
		High blood pressure: Who? _____			Colon cancer: Who? _____
		Heart attack/disease: Who? _____			Other Cancer: Who? _____
		High cholesterol: Who? _____			Substance abuse: Who? _____
		Diabetes: Who? _____			Alcoholism: Who? _____
		Sickle Cell Anemia: Who? _____			Depression: Who? _____
		Thyroid problem: Who? _____			Bipolar disorder: Who? _____
Yes	No	Questions	Yes	No	Questions
		Is your mother living? How old is she now (or when she died)? _____			Is your father living? How old is he now (or when he died)? _____

V. SOCIAL HISTORY

Yes	No	Questions
		Do you have cultural or religious needs that would affect your medical care? If yes, what? _____ _____
		Others living in your home, relationship _____

		What is your level of education? _____
		What is your present job? _____
		Do you have a Durable Power of Attorney for Health Care, Living Will, or DNR form? If yes, date completed: _____ Description: _____

VI. HEALTH HABITS & PREVENTIVE HEALTH

Yes	No	Questions	Describe
		Tobacco (type, amount per day)	
		Alcohol (drinks per week)	
		Do you use non-prescription or illicit drugs?	If yes, list: _____ If in the past, when was the last time?
		Trouble sleeping? (hours you sleep per night)	
		Weight gain/loss (unintentional) in the last 6 months?	
		Special diet? (explain)	
Yes	No	Questions	Describe
		Do you exercise? (type, days per week)	
		Date of Last Eye exam _____	
		Date of Last Dental exam _____	
		Date of Last Colonoscopy or stool test_____	
		Date of Last Tetanus shot (Td) _____	
		Date of Last Flu shot _____	
		Date of Last Pneumonia shot_____	
		Have you had a Hepatitis B (Hep B) series? If yes, date _____	
		Date of Last TB (tuberculosis) screen _____	

VII. FOR MEN ONLY. Have you had any of the following? (Check Yes or No):

Yes	No	Questions	Yes	No	Questions
		Prostate problems			Penis/testicle problems

VIII. FOR WOMEN ONLY. Have you had any of the following? (Check Yes or No; Fill in Blank):

Yes	No	Questions	Yes	No	Questions
		Problems with uterus/tubes/ovaries			# of Pregnancies. _____

		Menstrual problems			# of Live births. _____
		Breast problems (lump/discharge)			# of Miscarriages. _____
		Last mammogram (Date)_____			# of Abortions. _____
		Hysterectomy (Date)_____			Current birth control method: _____
		Last pap smear (Date)_____			
		Last bone density scan (Date)_____			

IX. CURRENT MEDICATIONS: Include any over the counter medicines, vitamins, and herbal supplements

Yes	No	Questions
		List all current medications: _____ _____ _____
		Are you allergic to any drug/medication? To a food/other substance? Please list and describe reactions(s): _____ _____

X. LEVEL OF INDEPENDENCE: (Check Yes or No):

Yes	No	Questions	Yes	No	Questions
		Do you use any of the following?			Do you need help with these activities?
		Cane			Preparing meals
		Walker			Eating
		Wheelchair			Using the bathroom
		Do you receive help in the home, such as home health, physical therapy, etc? If yes, what type? _____			Bathing
					Dressing
					Housework/Chores
					Taking medications
					Using the phone
					Managing money

To the best of my knowledge, I have answered every question completely and accurately. I will inform my provider of any change in my health or medications.

Patient or Guardian's Signature _____ Date _____