# FALLBROOK FAMILY HEALTH CENTER, LLC

## ADULT HISTORY FORM

Name _____ Date_____

Date of Birth _____ Age _____ Place of Birth _____

Marital Status _____ Occupation _____

**PRESENT HEALTH CONCERN, IF ANY:**

_____
_____
_____

**CHRONIC MEDICAL CONDITIONS:**

_____
_____
_____

**PAST MEDICAL HISTORY:**

**MEDICATIONS:** Are you taking any medication(s) regularly? Yes No
If yes, please list the name(s) and dosing schedule(s) on the lines below:

_____ _____
_____ _____
_____ _____
_____ _____

**ALLERGIES:** Are you allergic to any medications: Yes No
If yes, please list the name(s) below and the reaction type:

_____ _____
_____ _____

**SURGICAL HISTORY:** List any surgeries you have had and the date performed:

_____ _____
_____ _____
_____ _____

**OTHER HOSPITALIZATIONS:** If you have been hospitalized for other reason(s), list date(s) and reason(s):

_____ _____
_____ _____

**IMMUNIZATION HISTORY:**

Did you have all your childhood immunizations? Yes No Not sure
If applicable, date of last pneumonia immunization(s)? _____
If over age 60, date of shingles immunization? _____
Date of last tetanus immunization? _____
Date of last influenza immunization? _____

**SOCIAL HISTORY:**

Do you smoke? Yes No Never Chew tobacco? Yes No Never
If yes, how much? _____ And for how many years? _____
If you stopped smoking in the past, what was your quit date? _____
Do you drink caffeine each day? Yes No If yes, what type, how much?_____
Have you used street drugs? Yes No If yes, what type, how much, how often?_____
Do you drink alcohol? Yes No If yes, what type, how much, how often?_____
What are your hobbies? _____

**REVIEW OF SYSTEMS:**
Have you had any of the following problems (include both past and present)

**GENERAL:**

| | | |
|---|---|---|
| Anemia | Yes | No |
| Recent weight change | Yes | No |
| Thyroid problems | Yes | No |
| Diabetes or high blood sugar | Yes | No |
| Frequent fever or chills | Yes | No |

Other _____

**SKIN:**

| | | |
|---|---|---|
| Frequent rashes | Yes | No |
| Changing mole | Yes | No |

Other _____

**HEAD:**

| | | |
|---|---|---|
| Frequent headaches | Yes | No |
| Visual problems not corrected by glasses | Yes | No |
| Glaucoma | Yes | No |
| Frequent dizziness | Yes | No |
| Fainting | Yes | No |
| Epilepsy or seizures | Yes | No |
| Stroke | Yes | No |
| Weakness in arm or leg | Yes | No |
| Numbness | Yes | No |
| Hearing difficulty | Yes | No |
| Ringing in ears | Yes | No |
| Frequent nosebleeds | Yes | No |
| Frequent nasal congestion | Yes | No |
| Difficulty swallowing | Yes | No |
| Persistent hoarseness | Yes | No |
| Snoring | Yes | No |

Other _____

**LUNGS:**

| | | |
|---|---|---|
| Severe shortness of breath | Yes | No |
| Asthma or emphysema | Yes | No |
| Frequent cough | Yes | No |
| Coughing up blood | Yes | No |
| Tuberculosis | Yes | No |

Other _____

**HEART:**

| | | |
|---|---|---|
| High blood pressure | Yes | No |
| Rheumatic fever | Yes | No |
| Chest pain or pressure | Yes | No |
| Heart attack | Yes | No |
| Irregular heart beat | Yes | No |
| Swelling in legs | Yes | No |

Other _____

**GASTROINTESTINAL:**

| | | |
|---|---|---|
| Indigestion or heartburn | Yes | No |
| Ulcers | Yes | No |
| Frequent abdominal pain | Yes | No |
| Vomiting blood | Yes | No |
| Hepatitis or liver problems | Yes | No |
| Gallbladder problems | Yes | No |
| Frequent diarrhea | Yes | No |
| Frequent constipation | Yes | No |
| Rectal problems or bleeding | Yes | No |
| Black tar-like stools | Yes | No |
| Recent change in stools | Yes | No |

Colonoscopy yes/no date_____ location_____
Other _____

**URINARY:**

| | | |
|---|---|---|
| Kidney or bladder infection | Yes | No |
| Kidney stones | Yes | No |
| Burning with urination | Yes | No |
| Difficulty passing urine | Yes | No |
| Difficulty controlling urine | Yes | No |
| Getting up at night to urinate | Yes | No |
| Blood in urine | Yes | No |

Other _____

**PSYCHIATRIC:**

| | | |
|---|---|---|
| Depression | Yes | No |
| Anxiety | Yes | No |
| Suicidal Thoughts | Yes | No |
| Sleep too much or too little | Yes | No |

Other _____

**REPRODUCTIVE:**
Sexually Active: Yes Never Not currently active
Partners: □ Male □ Female
STD Yes No

**Male**:

| | | |
|---|---|---|
| Prostate problem | Yes | No |
| Discharge from penis | Yes | No |
| Lump in testicles | Yes | No |
| Difficulty having erections | Yes | No |

Other _____

**Female**:

| | | |
|---|---|---|
| Breast lump | Yes | No |

Mammogram yes/no date____ location_____

| | | |
|---|---|---|
| Discharge from nipple | Yes | No |
| Irregular periods | Yes | No |
| Abnormal vaginal bleeding | Yes | No |
| Severe cramps with periods | Yes | No |
| Abnormal pap test | Yes | No |

Last pap test was: _____
Age periods started: _____
Periods are: Heavy □ Medium □
Light □ Absent □
Date last menstrual period started: _____
Cycle: _____ days (from start to start)
Birth control method: _____
Number of full-term pregnancies: _____
Number of premature deliveries: _____
Number of abortions or miscarriages: _____
Number of living children: _____
Cesarean birth Yes No
Other: _____

**BONES/JOINTS:**

| | | |
|---|---|---|
| Painful or swollen joints | Yes | No |
| Persistent back or neck pain | Yes | No |
| Fractures and Dislocations | Yes | No |

Other _____

| FAMILY HISTORY | If Living | | If Deceased | |
|---|---|---|---|---|
| | Age | Health | Age at Death | Cause |
| **Father** | | | | |
| **Mother** | | | | |
| **Brothers/sisters** | | | | |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| **Children** | | | | |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |

| Has any blood relative ever had: | YES | NO | Relationship (check what applies) | Age at Onset |
|---|---|---|---|---|
| Cancer<br>Type of Cancer: | | | □ Maternal grandmother □ Paternal grandmother<br>□ Maternal grandfather □ Paternal grandfather<br>□ Other _____ | |
| Heart trouble | | | □ Maternal grandmother □ Paternal grandmother<br>□ Maternal grandfather □ Paternal grandfather<br>□ Other _____ | |
| Diabetes | | | □ Maternal grandmother □ Paternal grandmother<br>□ Maternal grandfather □ Paternal grandfather<br>□ Other _____ | |
| Stroke | | | □ Maternal grandmother □ Paternal grandmother<br>□ Maternal grandfather □ Paternal grandfather<br>□ Other _____ | |
| High blood pressure | | | □ Maternal grandmother □ Paternal grandmother<br>□ Maternal grandfather □ Paternal grandfather<br>□ Other _____ | |
| Thyroid problem | | | □ Maternal grandmother □ Paternal grandmother<br>□ Maternal grandfather □ Paternal grandfather<br>□ Other _____ | |
| Anesthesia or malignant hyperthermia problems | | | □ Maternal grandmother □ Paternal grandmother<br>□ Maternal grandfather □ Paternal grandfather<br>□ Other _____ | |
| Bleeding or blood clotting problems | | | □ Maternal grandmother □ Paternal grandmother<br>□ Maternal grandfather □ Paternal grandfather<br>□ Other _____ | |
| Other | | | □ Maternal grandmother □ Paternal grandmother<br>□ Maternal grandfather □ Paternal grandfather<br>□ Other _____ | |