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 Type of Cancer:			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	
Heart trouble			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	
Diabetes			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	
Stroke			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	
High blood pressure			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	
Thyroid problem			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	
Anesthesia or malignant hyperthermia problems			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	
Bleeding or blood clotting problems			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	
Other			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	