ADULT HISTORY

Name: _____ **Date**:_____ **DOB**:_____

Occupation: _____ **Highest Grade completed in school:** _____

I. Patient and Family History: List family members who have had any of the following. (Includes: mother, father, brother, sister, grandparents.)

	Self	Family	
• Diabetes	□	□	Who? _____
• High Blood Pressure	□	□	Who? _____
• Stroke	□	□	Who? _____
• Heart Problems	□	□	Who? _____
• Cancer	□	□	Who? _____
• Tuberculosis	□	□	Who? _____
• Depression	□	□	Who? _____
• Mental Illness	□	□	Who? _____
• Lung Problems (Asthma, COPD)	□	□	Who? _____
• Seizure	□	□	Who? _____
• Alcoholism	□	□	Who? _____
• Kidney Disease	□	□	Who? _____
• Arthritis	□	□	Who? _____
• Thyroid Problems	□	□	Who? _____
• Other	□	□	Who? _____

Date of Last Tetanus Shot? _____

II. Hospitalizations: List any hospitalizations you have had

Date	Cause	Hospital-Location

III. Allergies - List all allergies and drug reactions:

A._____

_____

B. Have you ever had a latex (rubber) allergy: Yes _____ No _____

IV. Medications: List ALL medications you currently take, including Prescriptions, Non-Prescription, Vitamins and Herbs. (Please specify the dosage and frequency.)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

V. Nutritional Screening:

_____No problem _____Diabetic _____ Not eating _____Takes liquids only
_____Nausea _____Trouble chewing or swallowing _____ History of Eating Disorder
_____Special Diet:_____ Other:_____
_____Dental Problems Last Dental Visit: _____

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VI. Substance Use:

Substance	No	Yes	If yes, list type i.e coffee and how much		Substance	None	Past	Current	How Often
Caffeine					Sedatives				
Tobacco					Inhalants				
Substance	**None**	**Past**	**Current**	**How often**	Cocaine				
Alcohol					Heroin				
Marijuana					Stimulants				
Meth					Other				

VII. Domestic Situation:

With whom do you live?_____
Are you able to care for yourself? Yes _____ No _____

VII. Advance Directives:

Do you have a Power of Attorney for Healthcare? Yes _____ No ____
Do you have a living will? Yes _____ No _____

*If yes, please provide a copy of the documents for your chart. Also, provide an updated copy any time you have changes made in the future.

If you would like more information on advance directives, please check here. _____

IX. Females Only:

Have you ever been pregnant? Yes □ No □ If yes, How many times? _____
How many living children do you have? _____
Have you ever had an abortion? Yes □ No □ If yes, When? _____

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