Seattle Healing Arts Center

ADULT HEALTH HISTORY

Name:________________________________ Today's Date:________________

Does your insurance cover physicals/preventive care? ☐ yes ☐ no ☐ I don't know

Your answers on this form will help your provider better understand your medical concerns and conditions. This form will be put in your medical record. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details.

Age:________ **How would you rate your general health?** ☐ Excellent ☐ Good ☐ Fair ☐ Poor

PRESENT HEALTH CONCERNS:________________________________

____

ALLERGIES/REACTIONS TO MEDICINES:____________________________

____

CURRENT MEDICATIONS: (Please include dose of Medicines/Vitamins/Supplements/Over the Counter Medicine/Birth Control Pills)

	NAME	DOSE		NAME	DOSE
1)			5)		
2)			6)		
3)			7)		
4)			8)		

PAST MEDICAL HISTORY: Indicate whether you have had any of the medical problems listed below by listing dates.

________ Alcohol/Drug Problem
________ Allergies/Hay Fever
________ Arthritis
________ Asthma/Emphysema
________ Bladder or Kidney Infection
________ Bleeding/clotting
________ Cancer
________ Osteoporosis
________ Diabetes
________ Depression/suicide attempt
________ Glaucoma
________ Heart disease/heart attack
________ High blood pressure
________ High cholesterol
________ Kidney Stones
________ Liver problem
________ Seizures
________ Sexually Transmitted Disease
________ Stroke
________ Thyroid condition
________ Tuberculosis
________ Other____________

SURGERIES/HOSPITALIZATIONS: Indicate whether you have had any surgery or hospitalizations by listing dates:

	SURGERY	DATE		SURGERY	DATE
1)			4)		
2)			5)		
3)			6)		

FAMILY HISTORY:

	Living?	Age now or at death	Major illnesses/cause of death
Mother:	______	______________	______________________________
Father:	______	______________	______________________________
Sister(s): #_____	______	______________	______________________________
Brother(s): #_____	______	______________	______________________________

HABITS:

Do you EXERCISE regularly? ☐ yes ☐ no What kind of exercise? ______________________ How long (minutes)? _______ How often? ______________	How would you rate your DIET? ☐ good ☐ fair ☐ poor Are you satisfied with your weight? ☐ yes ☐ no
CAFFEINE intake: ☐ none ☐coffee/tea_____cups/day ☐ chocolate _____ ☐soda drinks_____cans/bottles/day	Do you drink ALCOHOL? ☐ no ☐ yes Drinks/week_____ Is your alcohol use a concern for you or others? ☐ yes ☐ no
Do you use TOBACCO now? ☐ no ☐ yes cigarettes/day________ For how long? ________ Are you interested in quitting? ☐ yes ☐ no	Do you use TOBACCO previously? ☐ no ☐ yes cigarettes/day_____ For how long? __________ Are you interested in quitting? ☐ yes ☐ no

Do you use RECREATIONAL DRUGS? ☐ no ☐ yes:____

Your current sex partner(s) is/are: ☐ male ☐ female ☐ both ☐ none
Are you interested in being screened for sexually transmitted diseases: ☐ no ☐ yes

PREVENTIVE CARE: Indicate whether you have had any of the following by listing dates:

Complete physical exam______________	TB skin test (PPD)________________	Osteoporosis screening (Dexascan)________
Tetanus booster__________________	Flu Shot_______________________	Exam by eye doctor_______________
Chickenpox illess/Varicella Vaccine________	Rectal examination_______________	Dental Checkup__________________
Measles/mumps/rubella vaccine_________	Stool test for blood ______________	HIV/AIDS test___________________
Pneumonia vaccine________________	Colonoscopy____________________	________________________
Hepatitis B vaccine_______________	Cholesterol Tests________________	________________________

SOCIAL HISTORY: Birthplace:____________________Education:____________________Occupation:________________

Relationship/marital status:____________________________Number of children/ages:________________________

Who lives at home with you?____

Some patients can be hurt or threatened by someone they love. Is this happening to you? ☐ no ☐ yes Details:________________

Is violence at home a concern for you?____

WOMEN'S HEALTH HISTORY: First day of most recent menstrual period:________________________________

Do you have concerns about your periods? ☐ no ☐ yes Details:____________________________________

Age at first period:_______________ Frequency of periods:______________ Duration of periods:______________

Total # pregnancies:_____________ Births:__________________ Miscarriages:________ Abortions:________

Date of last PAP SMEAR:____________ History of abnormal Pap smear? ☐ no ☐ yes Details:___________________

Date of last MAMMOGRAM:__________ History of abnormal mammogram? ☐ no ☐ yes Details:_________________

If sexually active, method used to prevent pregnancy:____

Do you have concerns about menopause? ☐ no ☐ yes:____