FAMILY HEALTH CENTERS OF SAN DIEGO

ADULT HISTORY FORM

Patient Name:_____ DATE COMPLETED:_____

MEDICAL HISTORY:

Any serious past illnesses?: Yes/No

If yes, list, with age:

1) _____
2) _____
3) _____
4) _____
5) _____

List childhood diseases:

FAMILY HISTORY: Please check if anyone in the family has any of the following problems:

_____ Heart disease
_____ Diabetes
_____ High blood pressure
_____ Kidney disease
_____ Liver disease
_____ Birth disorders
_____ Sickle Cell disease
_____ Cancer, if yes please specify

_____ Anemia
_____ Epilepsy
_____ Mental illness
_____ Alcoholism
_____ Drug abuse
_____ Asthma
_____ Smoker in house
_____ Pets in house

_____

MEDICATIONS: List medications/dosages:

1) _____
2) _____
3) _____
4) _____

ALLERGIES: List allergies to medications or latex

1) _____
2) _____
3) _____
4) _____

REVIEW OF SYSTEMS Check all that apply:

HEAD AND NECK:

Severe headaches? ____
Dizzy spells? ____
Failing vision? ____
Eye pain? ____
Double vision? ____
See "floating lights"? ____
Severe hearing loss? ____
Ringing in ears? ____
Pain in ears? ____
Discharge from ear? ____
Repeated nosebleed? ____
Toothache at present? ____
Chronic nose obstruction? ____
Chronic sore tongue? ____
Persistent sore gums? ____
Prolonged hoarseness? ____
Swelling in neck? ____
Persistent neck rigidity? ____

FOR WOMEN ONLY:

Painful menstruation? ____
Excess menstruation? ____
Bleeding between periods? ____
Any missed periods? ____
Number of pregnancies: ____
Number of living children: ____

HEART AND LUNGS:

Chest pain on effort? ____
Skipping heart beats? ____
Difficult breathing? ____
Have night sweats? ____
Ankles swell? ____
Spit up blood? ____
Sit up to breathe easy? ____
Have chronic cough? ____
Any heart defects? ____

URINARY TRACT:

Any excess urination? ____
Any leakage of urine? ____
Scanty urination? ____
Any blood in urine? ____
Excess night urination? ____
Pain with urination? ____
Urinary shutdown? ____
Passed any stones? ____
Any bedwetting? ____
Any retention of urine? ____

STOMACH & INTESTINES:

Vomit blood? ____
Skin turn yellow? ____
Any chronic diarrhea? ____
Have hemorrhoids? ____
Chronic abdominal pain? ____
Persistent nausea? ____
Heart burn? ____
Appetite loss? ____
Any blood from rectum? ____
Clay colored stools? ____
Habitual constipation? ____
Any black tarry stools? ____

HABITS:

Cigarette/Alcohol? ____
Coffee? ____
Planned exercise? ____
Recreational drug use? ____
Balanced diet? ____

MUSCLES - JOINTS - NERVES:

Any tingling sensation? ____
Any numbness? ____
Disturbances in walking? ____
Any muscle jerking? ____
Any paralysis? ____
Any shaking? ____
Any limited motions? ____
Any joint trouble? ____
Nervous breakdown? ____
Any strokes? ____
Any memory loss? ____
Personality changes? ____
Speech disturbances? ____
Any seizures? ____
Any alcohol problem? ____
Any drug problem? ____
Any mental problem? ____
Any varicose veins? ____