

**Adult Health History for new patients**

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Patient information:

Name: Lindsey Whitaker
Age: 23
Height: 5'3" Weight: 130
Chief complaint: Shortness of air
Other concerns: Increased cough and wheezing

Review of Symptoms: Please mark the box and/or circle any persistent symptoms you have had in the past few months. Read through every section and select "no problems" if none of the symptoms apply to you.

*General*

- Unexplained weight loss / gain  
 Unexplained fatigue / weakness  
 Fall asleep during the day when sitting  
 Fever, chills  
 No problems

*Skin*

- New or change in mole  
 Rash / itching  
 No problems

*Ears/Nose/Throat*

- Nosebleeds, trouble swallowing  
 Frequent sore throats, hoarseness  
 Hearing loss / ringing in ears  
 No problems

*Eyes*

- Change in vision / eye pain / redness  
 No problems

*Cardiovascular*

- Chest pain / discomfort  
 Palpitations (fast or irregular heartbeat)  
 No problems

*Respiratory*

- Cough / wheeze  
 Loud snoring / altered breathing  
 Short of breath with exertion  
 No problems

*Gastrointestinal*

- Heartburn / reflux / indigestion  
 Blood in stool  
 Constipation  
 No problems

*Musculoskeletal*

- Neck pain  
 Back pain  
 Muscle/joint pain  
 No problems

*Hematologic/Lymphatic*

- Swollen Glands  
 Easy bruising  
 No problems

*Neurological*

- Headache  
 Memory loss  
 Fainting  
 Dizziness  
 Numbness/tingling  
 Unsteady gait  
 Frequent falls  
 No problems

*Psychiatric*

- Anxiety/ stress/ irritability  
 Lack of concentration  
 No problems

Family history: Indicate which relative has had the following diseases (parents and siblings are most important)

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's mom	Mom's dad	Dad's mom	Dad's dad
Alzheimer's								X
Asthma	X	X	X		X			
Cancer breast	X					X		
Cancer colon								
Cancer Lung								
Cancer other								
Coronary artery disease (e.g. heart attack, angina)								
Depression/Anxiety	X							
Diabetes								
Emphysema (COPD)	X	X						
Heart disease (CHF)		X						X
High blood pressure-hypertension	X				X		X	
High cholesterol		X					X	X
Migraine headaches								
Other	Glaucoma							

Other health issues:

Tobacco use:	YES	NO
Do you smoke?		X
If so, how long?		
How many packs per day?		
Alcohol use:		
Do you drink?	X	
How many drinks per week?	4-5	
Diet and exercise:		
Would you rate your diet as good, fair, or poor?	good	
Do you exercise regularly?	X	
If yes, how often?	4-5 times/week	

Thank you for taking the time to fill this out.