

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: Alan Wade
Age: 47
Height: 6'3" Weight: 275
Chief complaint: Chest pain, shoulder pain
Other concerns: Increased shortness of air

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
 Nausea
 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								
Asthma	X	X			X		X	
Cancer breast								
Cancer colon								
Cancer Lung		X						
Cancer other								
Coronary artery disease (e.g. heart attack, angina)		X					X	X
Depression/Anxiety			X					
Diabetes								
Emphysema (COPD)								
Heart disease (CHF)		X						X
High blood pressure-hypertension	X	X						
High cholesterol	X	X				X	X	X
Migraine headaches								
Other								

Other health issues:

Tobacco use:	YES	NO
Do you smoke?	X	
If so, how long?	2 years	
How many packs per day?	1/2	
Alcohol use:		
Do you drink?		X
How many drinks per week?		
Diet and exercise:		
Would you rate your diet as good, fair, or poor?	fair	
Do you exercise regularly?		X
If yes, how often?		

Thank you for taking the time to fill this out.