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: Sarah Smith
Age: 35
Height: 5'4'' Weight: 215
Chief complaint: Frequent urination and constant thirst
Other concerns: Weight loss without trying

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

Skin
____ New or change in mole
_x_ Rash / itching
____ No problems

Ears/Nose/Throat
____ Nosebleeds, trouble swallowing
____ Frequent sore throats, hoarseness
____ Hearing loss / ringing in ears
_x_ No problems

Eyes
____ Change in vision / eye pain / redness
_x_ No problems

Cardiovascular
____ Chest pain / discomfort
____ Palpitations (fast or irregular heartbeat)
_x_ No problems

Respiratory
____ Cough / wheeze
____ Loud snoring / altered breathing
_x_ Short of breath with exertion
____ No problems

Gastrointestinal
____ Heartburn / reflux / indigestion
____ Blood in stool
____ Constipation
_x_ No problems

Musculoskeletal
____ Neck pain
____ Back pain
____ Muscle/joint pain
_x_ No problems

Hematologic/Lymphatic
____ Swollen Glands
____ Easy bruising
_x_ No problems

Neurological
_x_ Headache
____ Memory loss
____ Fainting
____ Dizziness
_x_ Numbness/tingling
____ Unsteady gait
____ Frequent falls
____ No problems

Psychiatric
____ Anxiety/ stress/ irritability
____ Lack of concentration
_x_ 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								
Cancer breast	x							
Cancer colon								
Cancer Lung								
Cancer other								
Coronary artery disease (e.g. heart attack, angina)	x						x	x
Depression/Anxiety								
Diabetes	x	x		x	x	x	x	
Emphysema (COPD)								
Heart disease (CHF)		x						
High blood pressure-hypertension		x				x		
High cholesterol	x	x						
Migraine headaches								
Other								

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?		
Diet and exercise:		
Would you rate your diet as good, fair, or poor?	Poor	
Do you exercise regularly?		x
If yes, how often?		

Thank you for taking the time to fill this out.