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: John Doe
Age: 56
Height: 6'0'' Weight: 185
Chief complaint: Coughing up blood
Other concerns: Shortness of air and cough

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
____Rash / itching
_x_No problems
Ears/Nose/Throat
____Nosebleeds, trouble swallowing
_x_Frequent sore throats, hoarseness
____Hearing loss / ringing in ears
____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
_x_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
_x_Muscle/joint pain
____No problems
Hematologic/Lymphatic
_x_Swollen Glands
____Easy bruising
____No problems
Neurological
____Headache
____Memory loss
____Fainting
____Dizziness
____Numbness/tingling
____Unsteady gait
____Frequent falls
_x_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								
Asthma		x						
Cancer breast								
Cancer colon								
Cancer Lung		x		x		x	x	
Cancer other								
Coronary artery disease (e.g. heart attack, angina)								
Depression/Anxiety	x		x					
Diabetes								
Emphysema (COPD)		x						x
Heart disease (CHF)								
High blood pressure-hypertension								
High cholesterol	x	x						
Migraine headaches								
Other								

Other health issues:

Tobacco use:	YES	NO
Do you smoke?	x	
If so, how long?	25 years	
How many packs per day?	1-2	
Alcohol use:		
Do you drink?	x	
How many drinks per week?	2	
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.