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**ADULT HISTORY**

Name \_\_\_\_\_

Date Completed \_\_\_\_\_ Date of Birth \_\_\_\_\_

Have you ever had:		
Yes	No	
		Smoking
		Diabetes
		High blood pressure
		A heart murmur
		Heart trouble
		Heart attack
		High cholesterol
		Seizures
		Stroke
		Asthma
		Emphysema
		Hay fever/sinus problem
		Pneumonia
		Ulcers
		Hepatitis
		Thyroid Problem
		Arthritis
		Anemia
		Sexually transmitted infection
		Urinary infection
		Cancer
		Breast lump
		Abnormal PAP smear
		Drug or alcohol abuse
		Depression

ALLERGIES OR SEVERE REACTIONS TO MEDICATION OR FOOD		
<input type="checkbox"/> NONE		
Medication/food	Year of Reaction	What happened?

MEDICATIONS CURRENTLY TAKEN <input type="checkbox"/> NONE		
Medication	How Often	What for?

CHRONIC ILLNESS, SURGERY AND HOSPITALIZATIONS (Do not include emergency room visits or childbirth)	
Year	Why hospitalized/what surgery

<p><b>Do you exercise routinely?</b></p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
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STATEMENTS DESCRIBING YOUR USE OF MEDICATIONS: (Check one or more)
<input type="checkbox"/> Buy medication on my own to treat myself
<input type="checkbox"/> Never take medications unless prescribed
<input type="checkbox"/> Usually want a medication prescribed for my illness
<input type="checkbox"/> Willing to try non-drug treatments
<input type="checkbox"/> Strongly prefer non-drug treatments
<input type="checkbox"/> Never take drugs or only as last resort

**MENSTRUAL HISTORY**

Age periods began \_\_\_\_\_  
 Spacing of periods \_\_\_\_\_  
 (No. of days from first day of one to first day of next)  
 Duration \_\_\_\_\_  
 (No. of days of bleeding)  
 Amount of flow  Light  
                            Moderate  
                            Heavy  
 Age periods stopped \_\_\_\_\_

**BIRTH CONTROL**

**(check the statement which applies)**

Use birth control currently  
 Which method?  Condoms  
                            Birth control pills  
                            Other: \_\_\_\_\_  
 Do not use birth control

**OBSTETRICAL HISTORY**

Number of times pregnant \_\_\_\_\_  
 Number of full term babies \_\_\_\_\_  
 Number of premature babies \_\_\_\_\_  
 Number of abortions or miscarriages \_\_\_\_\_  
 Number of living children \_\_\_\_\_  
 Number of stillborn babies \_\_\_\_\_

**HEALTH SCREENING AND PREVENTION**

What was the year of your last:  
 Tetanus shot \_\_\_\_\_  
 Blood pressure measurement \_\_\_\_\_  
 Cholesterol test \_\_\_\_\_  
 Colonoscopy \_\_\_\_\_  
 (tube inserted into the rectum to screen colon cancer)  
**WOMEN ONLY:**  
 Pap smear \_\_\_\_\_  
 Mammogram (x-rays of the breast) \_\_\_\_\_  
 Breast exam by medical practitioner \_\_\_\_\_  
 Bone density test \_\_\_\_\_

**SMOKING HISTORY**

Smoking cigarettes currently:  
 Packs/day \_\_\_\_\_  
 Year started \_\_\_\_\_  
 Stopped smoking cigarettes  
 Year started \_\_\_\_\_  
 Year stopped \_\_\_\_\_  
 Packs/day when smoked \_\_\_\_\_  
 Smoke pipe or cigars currently  
 Smoked pipe or cigars in past  
 Never smoked

**ALCOHOL USE**

Do not drink alcohol currently  
 Currently do drink (even occasionally)  
 How often:  
 Less than 1 drink/month  
 1-3 drinks/month  
 1-3 drinks/week  
 1-3 drinks/day  
 How many drinks do you have at one time?  
 1 or 2 drinks  
 3 or 4 drinks  
 5 or more drinks  
 (One "drink" = one beer, one glass of wine, one shot of liquor or one mixed drink)

**FAMILY HISTORY**

	ALIVE		DEAD		
	Age	(check one) Well   Ill	Year of Death	Age at Death	Cause
Father					
Mother					
Brother(s)					
Sister(s)					
Spouse					
Children					