

FALLBROOK FAMILY HEALTH CENTER, LLC

ADULT HISTORY FORM

Name _____

Date _____

Date of Birth _____ Age _____

Place of Birth _____

Marital Status _____

Occupation _____

PRESENT PROBLEMS:

PAST MEDICAL HISTORY:

ALLERGIES:

Are you allergic to: Penicillin Yes No
Sulfa Yes No
Other medication Yes No
If yes, what? _____

MEDICATIONS:

Are you taking any medications regularly? Yes No
If yes, what? _____

OPERATIONS:

List any operations you have had and the date performed.

OTHER HOSPITALIZATIONS: If you have been hospitalized for other reasons, list dates and Reasons for hospitalizations:

Please circle answers

IMMUNIZATIONS:

Did you have all your childhood immunizations? Yes No
Date of last tetanus immunization? _____

PERSONAL HISTORY:

Do you smoke? Yes No Never Chew tobacco? Yes No
If yes, how much? _____

Have you ever smoked? Yes No Quit Date _____

How much caffeine do you drink each day? _____

Have you used street drugs? Yes No

Do you drink alcohol? Yes No

If yes, what type, how much, how often? _____

Any hobbies? _____

REVIEW OF SYSTEMS:

Have you had any of the following problems
(include both past and present)

GENERAL:

Anemia	Yes	No
Recent weight change	Yes	No
Thyroid problems	Yes	No
Diabetes or high blood sugar	Yes	No
Frequent fever or chills	Yes	No
Frequent large lymph glands or lumps	Yes	No
Other _____	Yes	No

SKIN:

Frequent rashes	Yes	No
Changing mole	Yes	No
Other _____	Yes	No

HEAD:

Frequent headaches	Yes	No
Visual problems not corrected by glasses	Yes	No
Glaucoma	Yes	No
Frequent dizziness	Yes	No
Fainting	Yes	No
Epilepsy or seizures	Yes	No
Stroke	Yes	No
Weakness in arm or leg	Yes	No
Numbness	Yes	No
Hearing difficulty	Yes	No
Ringing in ears	Yes	No
Frequent nosebleeds	Yes	No
Frequent nasal congestion	Yes	No
Difficulty swallowing	Yes	No
Persistent hoarseness	Yes	No
Snoring	Yes	No
Other _____	Yes	No

LUNGS:

Severe shortness of breath	Yes	No
Asthma or emphysema	Yes	No
Frequent cough	Yes	No
Coughing up blood	Yes	No
Tuberculosis	Yes	No
Other _____	Yes	No

HEART:

High blood pressure	Yes	No
Rheumatic fever	Yes	No
Chest pain or pressure	Yes	No
Heart attack	Yes	No
Irregular heart beat	Yes	No
Swelling in legs	Yes	No

Severe calf pain when walking	Yes	No
Other _____	Yes	No

GASTROINTESTINAL:

Indigestion or heartburn	Yes	No
Ulcers	Yes	No
Frequent abdominal pain	Yes	No
Vomiting blood	Yes	No
Hepatitis or liver problems	Yes	No
Gallbladder problems	Yes	No
Frequent diarrhea	Yes	No
Frequent constipation	Yes	No
Rectal problems or bleeding	Yes	No
Black tar-like bowel movements	Yes	No
Recent change in bowel habits	Yes	No
Other _____	Yes	No

URINARY:

Kidney or bladder infection	Yes	No
Kidney stones	Yes	No
Burning with urination	Yes	No
Difficulty passing urine	Yes	No
Difficulty controlling urine	Yes	No
Getting up at night to urinate	Yes	No
Blood in urine	Yes	No
Other _____	Yes	No

PSYCHIATRIC:

Depression	Yes	No
Anxiety	Yes	No
Thought about or attempted suicide	Yes	No
Sleep too much or too little	Yes	No
Other psychiatric problems _____		

Other _____

GENITALIA:

Men:

Prostate problem	Yes	No
Venereal disease (syphilis, Gonorrhea, etc.)	Yes	No
Discharge from penis	Yes	No
Lump in testicles	Yes	No
Difficulty having erections	Yes	No
Other _____	Yes	No

Women:

Breast lump	Yes	No
Discharge from nipple	Yes	No
Venereal disease (syphilis, Gonorrhea, etc.)	Yes	No

Irregular periods Yes No
Abnormal vaginal bleeding Yes No
Or spotting (not with periods)
Severe cramps with periods Yes No
Abnormal pap test
Last pap test was: _____
Age periods started: _____
Periods are: Heavy Medium
Light Absent
Date last menstrual period started: _____
Cycle: _____ days (from start to start)
Birth control method: _____

Number of full-term pregnancies: _____
Number of premature deliveries: _____
Number of abortions or miscarriages: _____
Number of living children: _____
Cesarean birth Yes No

BONES/JOINTS:

Painful or swollen joints Yes No
Persistent back or neck pain Yes No
Fractures and Dislocations Yes No
Other _____ Yes No

FAMILY HISTORY

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				
Brothers/sisters				
1.				
2.				
3.				
4.				
Children				
1.				
2.				
3.				
4.				

Has any blood relative ever had:	YES	NO	Relationship (circle what applies)	Age at Onset
Cancer Type of Cancer:			Grandmother/grandfather/maternal/paternal/other relative	
Heart trouble			Grandmother/grandfather/maternal/paternal/other relative	
Diabetes			Grandmother/grandfather/maternal/paternal/other relative	
Stroke			Grandmother/grandfather/maternal/paternal/other relative	
High blood pressure			Grandmother/grandfather/maternal/paternal/other relative	
Thyroid problem			Grandmother/grandfather/maternal/paternal/other relative	
Anesthesia or malignant hyperthermia problems			Grandmother/grandfather/maternal/paternal/other relative	
Bleeding or blood clotting problems			Grandmother/grandfather/maternal/paternal/other relative	
Mental illness			Grandmother/grandfather/maternal/paternal/other relative	
Other			Grandmother/grandfather/maternal/paternal/other relative	