DALLAS FAMILY PRACTICE, LLC
ADULT HEALTH HISTORY

rev 06/14

NAME _____ **Today's Date**_____

Date of Birth _____ ❑ Male ❑ Female

PAST MEDICAL HISTORY

HEALTH MAINTENANCE

Last Colonoscopy_____
Last Dexa Scan _____

Women Only
Last PAP_____
Last Mammogram_____
Last Self Breast Exam_____

Men Only
Date Last Testicular Exam_____

ILLNESS/INJURIES

Childhood Illness (Please List)

_____
_____
_____

Accidents/Injuries (Check Any You Have Had)

ORTHO / INJURY

❑ Broken Bones (fracture)
❑ Bone Dislocation
❑ Severe Laceration
❑ Concussion

Medical Problems

(Check Any You Have Had)

CARDIOVASCULAR
❑ High Blood Pressure
❑ Angina
❑ Chest Pains
❑ Heart Attack
❑ Heart Failure
❑ Rheumatic Fever

NEUROLOGIC
❑ Stroke
❑ Seizure
❑ Epilepsy
❑ Headaches
❑ Migraines
❑ Meningitis
❑ Poliomyelitis (POLIO)

HEME / ONCOLOGY
❑ Bleeding Disorder
❑ Sickle Cell Anemia
❑ Anemia
❑ Blood Coagulation D/O
❑ Cancer (Type)_____

PSYCH / ADDICTION
❑ Alcoholism
❑ Drug Addiction
❑ Depression
❑ Suicidal Thoughts
❑ Severe Anxiety (Panic)

MALE
❑ Frequent Urination During night
❑ Inability to Achieve Erection
❑ Unable To Empty Bladder Completely

CONGENTIAL
❑ Fetal DES Exposure
❑ Birth Defects

GENITO-URINARY
❑ History of Urinary Tract Infection
❑ Kidney Stones
❑ Kidney Failure
❑ Genital Herpes
❑ Chlamydia
❑ Gonorrhea
❑ Syphilis
❑ Genital Warts

RESPIRATORY
❑ Bronchitis (Recurrent)
❑ Pneumonia
❑ Asthma
❑ Allergies (seasonal)
❑ Tuberculosis (TB)
❑ Emphysema
❑ Chronic Obstr Pulm Disease **(COPD)**
❑ Sleep Apnea

ENDOCRINE
❑ Osteoporosis
❑ Diabetes (High Sugar)
❑ Thyroid Disease
❑ High Cholesterol

FEMALE
❑ Abnormal PAP (Cervical)
❑ Abnormal PAP (Vaginal)
❑ Complications in Pregnancy
EXPLAIN:_____

RHEUMATOLOGIC
❑ Chronic Back Pain
❑ Arthritis
❑ Gout

GASTROINTESTINAL
❑ Ulcer (Peptic, Gastric)
❑ Heartburn
❑ Irritable Bowel Syndrome
❑ Crohn's Disease
❑ Colitis
❑ Colon Polyps
❑ Pancreatitis
❑ Disorder of Gallbladder
❑ Hepatitis
❑ Cirrhosis

SPECIAL SENSES
❑ Vision Impairment
❑ Glaucoma
❑ Hearing Loss

DERMATOLOGIC
❑ Chronic Skin Disease/Condition
❑ Boils of Multiple Sites (recurrent)
❑ Acne

IMMUNITY
❑ Autoimmune Disease
❑ HIV Infection
❑ AIDS

OTHER
_____

NAME: _____

SURG / HOSPITALIZATION

List Any Operations You Have Had

DATE	SURGERY

List Other Hospitalizations or Serious Injuries

DATE	INJURY / HOSPITALIZATION

OB-GYN Hx

PREGNANCIES

Total # _____
Full Term _____
Premature _____
Stillbirth _____
Miscarriages _____
Abortions _____
Tubal Preg _____

MENSTRUAL HISTORY

Age Period Began _____
Period Interval (Cycle Length) _____
Duration (Period Length) _____
Date Last Menstrual Period _____
Flow (Average Throughout)
- ❑ Light
- ❑ Moderate
- ❑ Heavy

MENSTRUAL SYMPTOMS *(EXPLAIN)*

_____
_____
_____
_____

MENOPAUSAL HISTORY

Age of Menopause _____

SOCIAL HISTORY

1) GENERAL

MARITAL STATUS

- ❑ Married
- ❑ Single
- ❑ Widowed
- ❑ Divorced

❑ Children # ____
❑ Stepchildren # ____

LIVES WITH: _____

EDUCATION

Highest Level Completed _____
Degree(s) _____

OCCUPATION: _____

RELIGION (OPTIONAL) _____

HOME ENVIRONMENT

Violence at Home is a Concern ❑ Yes ❑ No
Guns in Home ❑ Yes ❑ No

DIET

Poor Appetite ❑ Yes ❑ No
Satisfied w/Current Weight ❑ Yes ❑ No
Diet (Special) Specify _____

2) PERSONAL HABITS

SMOKING

❑ Never Smoked ❑ Former Smoker
❑ Current Smoker (Specify)
- ❑ Cigarettes Amt Daily _____
- ❑ Cigars Amt Daily _____
- ❑ Pipe Amt Daily _____
- ❑ Smokeless Tobacco Amt Daily _____

2) PERSONAL HABITS con't

ALCOHOL

❑ Does Not Consume Alcohol
❑ Current Alcohol Use
Daily Amount _____ Weekly Amount _____
❑ Occasionally ❑ Rarely:

DRUG USE

❑ Marijuana ❑ Current User ❑ Former User
❑ Other Illicit Drugs ❑ Current User ❑ Former User
List: _____

DAILY CAFFEINE

- ❑ Coffee Amt Daily _____
- ❑ Tea Amt Daily _____
- ❑ Soda Amt Daily _____

EXERCISE

❑ None ❑ Regularly
❑ Rarely ❑ Sporadic

TATTOOS

❑ Yes ❑ No

SEATBELT USE

❑ Yes ❑ No

3) SEXUAL HISTORY

Contraceptive Method: _____
Lifetime # of Partners: _____
Average # of Partners per Year: _____
Additional Info:
Preference : ❑ Men
❑ Women
❑ Both

NAME: _____

FAMILY HISTORY

Check box if relative has	Mother	Father	Sister	Brother	Daughter	Son
Alcoholism						
Allergies						
Anemia						
Autoimmune Disease						
Arthritis						
Asthma						
Blood Coagulation Disorder						
Cancer						
COPD						
Depression						
Diabetes						
Eczema						
Emphysema						
Epilepsy						
Glaucoma						
Heart Disease						
High BP (Hypertension)						
High Cholesterol (Hypercholesterolemia)						
Irritable Bowel Syndrome						
Kidney Disease						
Mental Retardation						
Migraine Headaches						
Obesity						
Osteoporosis						
Seizure Disorder						
Stroke						
Substance Abuse						
Suicide						
Thyroid Disorder						
Tuberculosis						
Other:						
Other :						

DALLAS FAMILY PRACTICE, LLC

MEDICATION, IMMUNIZATION and CONCURRENT CARE

NAME _____ Today's Date_____

LIST ALL CURRENT MEDICATIONS

Check if NONE ❑

NAME	DOSE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

❑ VITAMINS or SUPPLEMENTS (list)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

❑ Birth Control Pills _____

LIST ALLERGIES

_____ _____

_____ _____

IMMUNIZATIONS

Please CHECK ☑ if you had the following IMMUNIZATIONS and List DATE

- ❑ Pneumonia (Pneumovax) Shot: _____
- ❑ Tetanus Shot: _____
- ❑ Smallpox Vaccine:_____
- ❑ Meningococcal Vaccin :_____
- ❑ Hepatitis A Series: _____
- ❑ Hepatitis B Series: _____
- ❑ Flu Shot (Influenza: _____
- ❑ TB Skin Test (PPD) : _____
  - ❑ Positive ❑ Negative
- ❑ Chicken Pox Vaccine (or disease): _____
- ❑ Zoster Vaccine (Shingles): _____

CONCURRENT CARE

(LIST ANY OTHER PROVIDERS/ SPECIALISTS WHOSE CARE YOU ARE UNDER)

_____ Reason_____

_____ Reason_____

_____ Reason_____