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**Adult Health History Form**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Main Reason for Today's Visit: \_\_\_\_\_

**Preferred Pharmacy**

Name: \_\_\_\_\_ Location: \_\_\_\_\_

**Personal Medical History:** Please, indicate whether you have had any of the following medical problems:

- Heart Disease: \_\_\_\_\_  
Specify type: \_\_\_\_\_
- Asthma/Lung Disease
- Cancer (specify): \_\_\_\_\_
- High Blood Pressure
- Diabetes
- Sleep Apnea
- Other (specify): \_\_\_\_\_
- Thyroid Problem
- Acid Reflux
- Bleeding Disorder

**Surgical History:** Please, list all prior operations – with dates.

| Procedure: | Date  | Procedure | Date  |
|------------|-------|-----------|-------|
| _____      | _____ | _____     | _____ |
| _____      | _____ | _____     | _____ |

**Medications:** Prescription and non-prescription medications, vitamins, supplements, herbals, ect.

| Medication: | Dose: | Medication: | Dose: |
|-------------|-------|-------------|-------|
| _____       | _____ | _____       | _____ |
| _____       | _____ | _____       | _____ |
| _____       | _____ | _____       | _____ |

**Allergies:** please, list any allergies to medications along with reaction.

| Allergic to: | Reaction | Allergic to: | Reaction: |
|--------------|----------|--------------|-----------|
| _____        | _____    | _____        | _____     |
| _____        | _____    | _____        | _____     |

Do you have environmental or food allergies Yes/No  
If Yes, what: \_\_\_\_\_

Have you ever been evaluated with allergy tests? Yes/No

**Family History:** Indicate family members (parents, sibling, grandparent, aunt or uncle) with the following:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problem          |
| <input type="checkbox"/> Stroke                | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Headaches                |
| <input type="checkbox"/> Asthma/Lung Disease   | <input type="checkbox"/> Sleep Apnea         | <input type="checkbox"/> Bleeding Disorder        |
| <input type="checkbox"/> Cancer (specify)_____ | <input type="checkbox"/> Hearing Loss        | <input type="checkbox"/> Problems with anesthesia |

**Social History:**

Occupation: \_\_\_\_\_

**Tobacco Use:**

- |                |                                |  |   |
|----------------|--------------------------------|--|---|
| Cigarettes?    | <input type="checkbox"/> Never | <input type="checkbox"/> Quit Date _____ | <input type="checkbox"/> Current Smoker: packs/day _____ # of years _____ |
| Other Tobacco? | <input type="checkbox"/> Pipe  | <input type="checkbox"/> Cigar           | <input type="checkbox"/> Snuff <input type="checkbox"/> Chew              |

**Alcohol Use:**

- Do you drink alcohol?  No  Yes Drinks/Week \_\_\_\_\_

**Drug Use:**

- Do you use recreational drugs?  No  Yes

- Caffeine Intake:  None  Coffe/Tea/Soda – Cups/Day \_\_\_\_\_

**Review of Systems:** Do you have problems with any of the following?

- |                            |                             |   |  |
|----------------------------|-----------------------------|---|--|
| <b>General Health:</b>     | <input type="checkbox"/> No | <input type="checkbox"/> Fever                        | <input type="checkbox"/> Unintentional weight loss   |
| <b>Sleeping:</b>           | <input type="checkbox"/> No | <input type="checkbox"/> Snoring                      | <input type="checkbox"/> Apnea <input type="checkbox"/> Waking up Tired <input type="checkbox"/> Daytime Tiredness                               |
| <b>Eyes:</b>               | <input type="checkbox"/> No | <input type="checkbox"/> Visual Loss                  | <input type="checkbox"/> Blurry Vision <input type="checkbox"/> Itchy Eyes <input type="checkbox"/> Tearing                                      |
| <b>Ears:</b>               | <input type="checkbox"/> No | <input type="checkbox"/> Dizziness                    | <input type="checkbox"/> Ringing <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Earache <input type="checkbox"/> Drainage        |
| <b>Nose:</b>               | <input type="checkbox"/> No | <input type="checkbox"/> Drainage                     | <input type="checkbox"/> Congestion <input type="checkbox"/> Post-nasal Drip <input type="checkbox"/> Bleeding <input type="checkbox"/> Sneezing |
| <b>Mouth &amp; Throat:</b> | <input type="checkbox"/> No | <input type="checkbox"/> Sore Throat                  | <input type="checkbox"/> Hoarseness <input type="checkbox"/> Voice Change <input type="checkbox"/> Problem Swallowing                            |
|                            |                             | <input type="checkbox"/> Dentures                     | <input type="checkbox"/> Mouth Sores   |
| <b>Neck:</b>               | <input type="checkbox"/> No | <input type="checkbox"/> Pain                         | <input type="checkbox"/> Lumps <input type="checkbox"/> Thyroid Nodule <input type="checkbox"/> Swollen Glands                                   |
| <b>Cardiovascular:</b>     | <input type="checkbox"/> No | <input type="checkbox"/> Chest Pain                   | <input type="checkbox"/> Irregular Heart beat <input type="checkbox"/> Murmurs <input type="checkbox"/> Swelling                                 |
|                            |                             | <input type="checkbox"/> Heart Valve Disease          |  |
| <b>Lungs:</b>              | <input type="checkbox"/> No | <input type="checkbox"/> Chronic Cough                | <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of Breath   |
|                            |                             | <input type="checkbox"/> Positive TB Test             |  |
| <b>Gastrointestinal:</b>   | <input type="checkbox"/> No | <input type="checkbox"/> Heartburn                    | <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea      |
| <b>Genitourinary:</b>      | <input type="checkbox"/> No | <input type="checkbox"/> Frequent Nighttime Urination | <input type="checkbox"/> Pain <input type="checkbox"/> Incontinence <input type="checkbox"/> Bloody urine  |
| <b>Musculoskeletal:</b>    | <input type="checkbox"/> No | <input type="checkbox"/> Muscle Pain                  | <input type="checkbox"/> Back Pain <input type="checkbox"/> Neck Pain <input type="checkbox"/> Joint Pain  |
| <b>Neurological:</b>       | <input type="checkbox"/> No | <input type="checkbox"/> Headaches                    | <input type="checkbox"/> Migraines <input type="checkbox"/> Tremors <input type="checkbox"/> Numbness <input type="checkbox"/> Memory loss       |
| <b>Psychiatric:</b>        | <input type="checkbox"/> No | <input type="checkbox"/> Anxiety                      | <input type="checkbox"/> Nervousness <input type="checkbox"/> Depression <input type="checkbox"/> Mood Swings                                    |
| <b>Endocrine:</b>          | <input type="checkbox"/> No | <input type="checkbox"/> Increased Appetite           | <input type="checkbox"/> Feeling hot when others are not <input type="checkbox"/> Cold   |
|                            |                             | <input type="checkbox"/> Recent Weight Changes -      | <input type="checkbox"/> Gain <input type="checkbox"/> Loss  |
| <b>Blood/Lymph:</b>        | <input type="checkbox"/> No | <input type="checkbox"/> Slow to Heal after Cuts      | <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Anemia   |
|                            |                             | <input type="checkbox"/> Bleeds Excessively           | <input type="checkbox"/> Unexplained Lumps   |
| <b>Skin:</b>               | <input type="checkbox"/> No | <input type="checkbox"/> Rash                         | <input type="checkbox"/> Hives   |

**Signatures:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Relationship to Patient (if other than self) \_\_\_\_\_

