Family Practice of Cadillac, P.C.

Adult Health History Form

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control, herbs, etc.

Medication Dose (e.g., mg/pill) How many times per day

_____

_____

_____

_____

Allergies or reactions to medications: ❑ None _____

OTHER HEALTHCARE PROVIDERS: List any providers you see including eye doctors, dentist, chiropractors, etc.

_____

_____

HEALTH MAINTENANCE SCREENING TESTS:

Sigmoidoscopy_____ or Colonoscopy _____ Date_____ Abnormal? ❑ Yes ❑ No

Women: Mammogram: Date_____ Abnormal? ❑ Yes ❑ No

Pap Smear: Date_____ Abnormal? ❑ Yes ❑ No

Dexascan (osteoporosis): Date_____ Abnormal? ❑ Yes ❑ No

Men: PSA (prostate): Date_____ Abnormal? ❑ Yes ❑ No

Last Eye Exam: Date_____

Last Dental Exam: Date_____

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems.

❑ Heart disease:
specify type_____
❑ Asthma/Lung disease
❑ Frequent or difficult urination
❑ High blood pressure
❑ Diabetes
❑ Thyroid problems
❑ Other: (specify)_____
❑ High cholesterol
❑ Kidney disease
❑ Cancer: (specify)_____

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism_____
Cancer, specify type_____
Heart disease_____
Depression/suicide_____
Genetic disorders_____
Diabetes_____
High cholesterol_____
High blood pressure_____
Stroke_____
Bleeding or clotting disorder_____
Asthma/COPD_____
Other_____

Patient's Name_____DOB_____Date_____

SURGICAL HISTORY: Please list all prior operations (with dates):

_____

WOMEN'S HEALTH HISTORY: # pregnancies_____ # deliveries_____ # abortions_____ # miscarriages_____

Age at start of periods_____ Age at end of periods_____

SOCIOECONOMICS: Occupation_____ Employer_____

Spouse/partner's name_____ Number of children/ages_____

SOCIAL HISTORY:

Tobacco Use

Cigarettes: ❑ Never ❑ Quit Date_____ ❑ Current Smoker: packs/day_____ # of years_____

Other Tobacco: ❑ Pipe ❑ Cigar ❑ Chew

Are you interested in quitting? ❑ Yes ❑ No

Alcohol Use

Do you drink alcohol? ❑ No ❑ Yes # drinks/week_____

Is your alcohol use a concern for you or others? ❑ Yes ❑ No

Drug Use

Do you use any recreational drugs? ❑ Yes ❑ No

Have you ever used needles to inject drugs? ❑ Yes ❑ No

MENTAL ASSESSMENT:

Over the past two weeks, have you felt down, depressed or hopeless? ❑ Yes ❑ No

Over the past two weeks, have you felt little interest or pleasure in doing things? ❑ Yes ❑ No

DIET and EXERCISE:

Do you exercise regularly? ❑ Yes ❑ No

What kind of exercise?_____ How long (minutes)_____ How often_____

If you do not exercise, why not?_____

How often do you have caffeine? ❑ None ❑ Coffee/tea/soda ____ cups/day

SAFETY:

Do you feel safe in your home? ❑ Yes ❑ No

Is violence at home a concern for you? ❑ Yes ❑ No

Have you ever been abused? ❑ Yes ❑ No

Date Reviewed:	By (initials):

Patient's Name_____DOB_____Date_____