Dunkirk Family Practice
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Adult Health History
(Confidential)

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important.

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

ALLERGIES

List anything you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION

FAVORITE PHARMACY _____

MEDICATIONS

List all medications you're taking, including prescribed drugs and over the counter drugs, i.e., vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN

IMMUNIZATIONS

Immunizations and most recent date:

☐ Chicken Pox	Date:	☐ Meningococcus	Date:
☐ Flu Shot	Date:	☐ MMR (Measles, Mumps, Rubella)	Date:
☐ Gardasil/HPV	Date:	☐ Pneumonia	Date:
☐ Hepatitis A	Date:	☐ tDAP (Tetanus, Diphtheria, Pertussis)	Date:
☐ Hepatitis B	Date:	☐ Tetanus	Date:
☐ Zostavax (Shingles)	Date:		

Name: _____ DOB: _____

PAST MEDICAL HISTORY (Please check all that apply)

☐ Anxiety Disorder	☐ Diverticulitis	☐ Kidney Disease
☐ Arthritis	☐ Fibromyalgia	☐ Kidney Stones
☐ Asthma	☐ Gout	☐ Leg/Foot Ulcers
☐ Bleeding Disorder	☐ Has Pacemaker	☐ Liver Disease
☐ Blood Clots	☐ Heart Attack	☐ Osteoporosis
☐ Cancer	☐ Heart Murmur	☐ Polio
☐ Coronary Artery Disease	☐ Hiatal Hernia or Reflux Disease	☐ Pulmonary Embolism
☐ Claustrophobic	☐ HIV or AIDS	☐ Reflux or Ulcers
☐ Diabetes- Insulin	☐ High Cholesterol	☐ Stroke
☐ Diabetes- Non-Insulin	☐ High Blood Pressure	☐ Tuberculosis
☐ Dialysis	☐ Overactive Thyroid	☐ Other

OBSTETRIC AND GYNECOLOGICAL HISTORY (WOMEN ONLY)

Last PAP Smear	Date:	☐ Abnormal	CHECK BELOW IF APPLIES TO YOU:
Last Mammogram	Date:	☐ Abnormal	☐ Bleeding between periods
Age of First Menstrual Period			☐ Heavy Periods
Last Period/Age of Menopause (Date/Age):			☐ Extreme Menstrual Pain
Number of Pregnancies:			☐ Vaginal itching, burning, or discharge
Number of Miscarriages:			☐ Waking in the night to go to the bathroom
Number of Cesarean sections:			☐ Breast lump or nipple discharge
Number of Births:			☐ Hot Flashes
Number of Abortions:			☐ Painful Intercourse
Current Sexual Partner:	☐ Female ☐ Male		☐ Sexually Active
Do you use condoms?	☐ Yes	☐ No	
Other Birth Control Method Used:			
Interested in being screened for STDs:	☐ Yes	☐ No	

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL

Name: _____ DOB: _____

FAMILY HEALTH HISTORY

SIGNIFICANT HEALTH PROBLEMS IN MY FAMILY											
RELATION	**ALIVE?**	**AGE**	**ALCOHOLISM**	**ARTHRITIS**	**DEPRESSION**	**CANCER**	**DIABETES**	**GENETIC DISEASE**	**HEART DISEASE**	**OSTEOPOROSIS**	**STROKE**
GRANDMOTHER (MATERNAL)	☐ Y ☐ N										
GRANDFATHER (MATERNAL)	☐ Y ☐ N										
GRANDMOTHER (PATERNAL)	☐ Y ☐ N										
GRANDFATHER (PATERNAL)	☐ Y ☐ N										
FATHER	☐ Y ☐ N										
MOTHER	☐ Y ☐ N										
BROTHER/SISTER	☐ Y ☐ N										
BROTHER/SISTER	☐ Y ☐ N										
OTHER:	☐ Y ☐ N										

ADDITIONAL HEALTH FACTS

Please add other information about your health that you would like your provider to know here:

Name: _____ DOB: _____

SOCIAL HISTORY

<table>
<tr><th>EDUCATION</th><th colspan="2">MARITAL STATUS</th><th>EXERCISE</th><th>CAFFEINE</th></tr>
<tr><td>☐ < 8TH Grade
☐ High School
☐ 2 Yr. College
☐ 4 Yr. College
☐ Post Graduate</td><td colspan="2">☐ Married
☐ Single
☐ Divorced
☐ Separated
☐ Widowed
☐ Domestic Partner</td><td>☐ No exercise
☐ Occasional Exercise
☐ Moderate Exercise
☐ High Level Exercise</td><td>☐ None
☐ Occasional
☐ Moderate
☐ Heavy

cups/cans a day _____</td></tr>
<tr><th>ALCOHOL</th><th colspan="2">TOBACCO</th><th colspan="2">DRUGS</th></tr>
<tr><td>Drink Alcohol?
☐ Yes
☐ No</td><td colspan="2">Do you use Tobacco?
☐ Yes
☐ No</td><td colspan="2">Do you currently use recreational or street drugs?
☐ Yes (Please list)
☐ No</td></tr>
<tr><td>How Often?
☐ Occasionally
☐ < 3 times/week
☐ > 3 times/week
Drinks/week? ___</td><td>If not now, did you ever use tobacco?
☐ Cigarettes___ pks./day
☐ Chew ____/day
☐ Cigars ___/day
Years Used ____
Or Year Quit_____</td><td>☐ Yes
☐ No</td><td colspan="2"></td></tr>
</table>

By signing below, I agree the information of this document to be true and updated to the best of my knowledge.

_____ _____

PATIENT, GUARDIAN OR CAREGIVER SIGNATURE **DATE**