ADVANCED MEDICAL CONSULTATIONS, LTD
Tel: 630 366 6681, Fax: 630 366 6550
Web: www.mconsultations.com
715 W. Lake Street, Suite 104, Addison, IL, 60101

# Adult Health History Form

_____
*Name* *Date*

*Your answers on this form will help your healthcare 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 provide your best guess. Thank you!*

**What is the reason for your visit today?** _____

How would you rate your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

**REVIEW OF SYMPTOMS: Please check any current symptoms you have.**

**Constitutional**
___Unexplained weight loss/gain
___Unexplained fatigue/weakness

**Eyes**
___Change in vision

**Ears/Nose/Throat/Mouth**
___Difficulty hearing/ringing in ears
___Trouble swallowing
___Sinus Allergies

**Cardiovascular**
___Chest pain/discomfort
___Palpitations
___Shortness of breath with exertion

**Breast**
___Breast lump
___Nipple discharge

**Respiratory**
___Cough/wheeze

**Gastrointestinal**
___Heartburn/reflux
___Blood or change in bowel movement
___Nausea/vomiting/diarrhea

**Genitourinary**
___Painful/bloody urination
___Leaking urine
___Nighttime urination
___Discharge: penis or vagina
___Unusual vaginal bleeding
___Concern with sexual functions

**Musculoskeletal**
___Muscle/joint pain
___Back pain

**Skin**
___Rash
___New or change in mole

**Neurological**
___Memory loss
___Fainting

**Psychiatric**
___Anxiety/stress
___Sleep Problem

**Blood/Lymphatic**
___Unexplained lumps
___Easy bruising/bleeding

**Endocrine**
___Cold/heat intolerance
___Increase thirst/appetite

In the past month, have you had little interest or pleasure in doing things, felt sad or down, depressed or hopeless?
❑Yes ❑No

**Do you have any ALLERGIES or reactions to any MEDICATIONS or other non-medications**?

YES:_____ NO:_____ If answer is yes, please list **MEDICATION and TYPE of REACTION** on first line and other allergies (foods, seasonal) on the second line:

_____

_____

SURGICAL HISTORY: Please list **ANY and ALL prior operations (including as a child**) and provide dates, if unsure, please include your age or year:

_____
_____
_____
_____
_____
_____
_____

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_____

*Name* *Date*

Date of your most recent **IMMUNIZATIONS**:

Hepatitis A_____ Hepatitis B_____ Influenza (flu shot)_____ MMR_____ Tetanus (Td)_____
Pneumovax (pneumonia)_____Meningitis_____ Varicella (chicken pox) shot or Illness_____
HPV_____Zostavax (Shingles)_____

**HEALTH MAINTENANCE SCREENING TESTS:**

Lipid (cholesterol) & Sugar_____ Date_____ Abnormal? ❑Yes ❑No
Sigmoidoscopy_____ or Colonoscopy_____ Date_____ Abnormal? ❑Yes ❑No

**Women**: Mammogram Date_____Abnormal? ❑Yes ❑No Pap Smear Date_____ Abnormal? ❑Yes ❑No
Have you ever had a Dexa Scan (for bone density) ❑Yes ❑No Abnormal? Date _____

**Women's Health History**: Number of: pregnancies_____ deliveries_____ abortions_____ miscarriages_____
Age at start of periods: _____ Date of Last Period: _____ Age at end of periods: _____

**Name and phone number of your OB/Gynecologist:**_____

**Men's Health History**:
Have you had a blood test for: PSA (prostate) ❑Yes ❑No If yes, what date _____ Was it normal? _____

**PERSONAL MEDICAL HISTORY: Please indicate whether <u>YOU</u> have had any of the following medical problems (with dates).**

Alcoholism_____
Anxiety / Depression_____
Cancer, specify type_____
Heart disease_____
Diabetes_____
Stroke_____
Urinary / Kidney Problems_____
Arthritis / Rheumatologic_____
Bleeding or Clotting disorder or
Blood Clot_____
Thyroid problems_____
High Blood Pressure_____
High Cholesterol_____
Other_____

**Do you see any other doctors? If yes, please list their name, office phone number and specialty.**

_____

_____

_____

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_____

*Name* *Date*

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

| Relative | Date of Birth | Alive/ Deceased (list age when died) | List any Health Problems or Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brother | | | |
| Brother | | | |
| Sister | | | |
| Sister | | | |
| Child | | | |
| Child | | | |
| Child | | | |

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_____
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**SOCIAL HISTORY**

Cigarettes ❑Never ❑Quit Date_____

❑ Current Smoker: packs/day_____ # of yrs_____

Other Tobacco: ❑Pipe ❑Cigar ❑Snuff ❑Chew

Are you interested in quitting? ❑No ❑Yes

**Alcohol Use**
Do you drink alcohol? ❑No ❑Yes
If yes: how many drinks per day _____
how many drinks per week? _____
how many drinks per occasion?_____

**Sexual Activity**
Sexually active: ❑Yes ❑No ❑Not currently
Current sex partner(s) is/are: ❑male ❑female

Birth control method:_____❑None needed
❑Unprotected intimate contact

Have you ever had any sexually transmitted diseases (STDs)? ❑No ❑Yes

Are you interested in being screened for sexually transmitted diseases? ❑No ❑Yes

**OTHER:**
Hobbies:_____

_____

_____

_____

Advanced Medical Consultations

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**Caffeine Use:** ❑None
Coffee _____ cups/day
Tea _____ cups/day
Soda _____ cups/day

Weight: Are you satisfied with your weight? ❑No ❑Yes

If no, are you currently trying to lose weight?
❑No ❑Yes

If yes, what method are you using and for how long have you been trying?

_____

_____

Diet: How do you rate your diet? ❑Good❑Fair ❑Poor

Do you use any recreational drugs? ❑No ❑Yes
Have you ever used needles to inject drugs? ❑No ❑Yes

Exercise: Do you exercise regularly? ❑No ❑Yes

If yes, what kind(s) of exercise or physical activity:
_____

_____

_____

_____