ADULT AND FAMILY HEALTH HISTORY

Date:

Patient’s Name: D.O.B: Age:

How would you generally describe your overall health:

**Are you currently or have you ever been treated for the following:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Yes | No | Condition | Yes | No | Condition | Yes | No | Condition |
|  |  | Allergies |  |  | Gastro-Intestinal Problem |  |  | Sickle Cell Disease |
|  |  | Asthma |  |  | Heart Disease |  |  | Sleep Disorders |
|  |  | Bleeding Disorder |  |  | Kidney Disease |  |  | Stroke |
|  |  | Blood Pressure |  |  | Learning Disorder |  |  | Surgery |
|  |  | COPD |  |  | Menstrual Problem |  |  | Thyroid Disease |
|  |  | Diabetes |  |  | Musculo-Skeletal Problem |  |  | Serious Injury |
|  |  | Ear / Sinus Problem |  |  | Psychological / Psychiatric |  |  | Other: |
|  |  | Fainting |  |  | Seizures |  |  | Other: |

Please explain yes answer (as needed):

**Medication(s) you are currently taking, please include over-the-counter drugs, herbal supplements and vitamins**

|  |  |  |
| --- | --- | --- |
| Medication | Dosage | Reason you are taking medication |
|  |  |  |
|  |  |  |
|  |  |  |
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| --- |
| Medication Allergies – please include medication and corresponding allergic reaction (i.e. hives, rash, fever…) |

**Relevant Family History**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Condition | Parents | | Siblings | | Mother’s  Family | | Father’s  Family | | Describe |
| Yes | No | Yes | No | Yes | No | Yes | No |
| Mental Health Issues |  |  |  |  |  |  |  |  |  |
| Suicide Attempts / Completions |  |  |  |  |  |  |  |  |  |
| Alcohol Abuse / Dependence |  |  |  |  |  |  |  |  |  |
| Drug Abuse / Dependence |  |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |  |  |  |

Additional health information you may consider relevant: