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ADULT HEALTH HISTORY

Date _____

Name _____
Date of birth _____ Age _____
General health _____

Are you currently or have you ever been treated for?

		Condition	Explain
☐	☐	Asthma	
☐	☐	Bleeding disorders	
☐	☐	Blood Pressure	
☐	☐	COPD	
☐	☐	Diabetes	
☐	☐	Ear/sinus	
☐	☐	Fainting	
☐	☐	Gastro-intestinal problems	
☐	☐	Heart disease	
☐	☐	Kidney disease	
☐	☐	Learning disorders	
☐	☐	Menstrual problems	
☐	☐	Musculo-skeletal	
☐	☐	Psychological/psychiatric	
☐	☐	Seizures	
☐	☐	Sickle cell disease	
☐	☐	Sleep disorders	
☐	☐	Stroke	
☐	☐	Surgery	
☐	☐	Thyroid disease	
☐	☐	Serious injury	
☐	☐	Other	
		Pertinent family history	
		Social history: Alcohol Yes ( ) NO ( )	**Drug use:** Yes ( ) NO ( ) **Smoking:** Yes ( ) NO ( ) or Former ( )
		Pain Scale 1-10:	Pain location:
		Urinary incontinence Yes ( ) NO ( )	
		Depression Yes ( ) NO ( )	
		Flu shot Yes ( ) NO ( )	Date:
		Tetanus vaccine: Yes ( ) NO ( )	Date:
		Influenza vaccine: Yes ( ) NO ( )	Date:
		Zoster vaccine Yes ( ) NO ( )	Date:
		Pneumonia vaccine Yes ( ) NO ( )	Date:
		Elder abuse screen	
		Fall Risk Yes ( ) NO ( )	

Allergies

Signature _____