

Adult Health History

Sterling Square Primary Care

Name _____ Birth Date ____/____/____ Gender M F
Last First M

Place of Employment _____ How Long? _____ Occupation _____

Single Married Separated Divorce Widowed Highest Grade Completed _____

Do you have someone available to assist you in time of need? yes no

If married, spouse's name _____

Children's names and ages _____

Do you live alone? yes no Do you drive? yes no

Do you have any special spiritual or religious needs? yes no

Do you have any special cultural needs? yes no

Main language that you speak _____

Any ALLERGIES to medications, x-ray dyes, foods, or other substances? yes no If so, what type of reaction?

Past Medical History & Review of Systems

Please mark the box if you have had problems with or are presently complaining of any of the following:

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Venereal Diseases | <input type="checkbox"/> Unexplained Weight Gain/Loss |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> T.B. | <input type="checkbox"/> Colitis | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Skin Diseases |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> Depression | <input type="checkbox"/> Hearing Difficulty |
| <input type="checkbox"/> Chest/Pain Discomfort | <input type="checkbox"/> Abdominal Discomfort | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Head or Neck Radiation | <input type="checkbox"/> Alcohol Abuse | |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Headache | <input type="checkbox"/> Drug Abuse | |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney Diseases | <input type="checkbox"/> Gout | |
| <input type="checkbox"/> Light Headedness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Difficulty Eating | |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Impotency | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Change in Bowel Habits | <input type="checkbox"/> Low Back Problems | <input type="checkbox"/> Corrective Eyewear | |

Any problems not listed above _____

Level of Independence	Self	Need Assistance
Eating/Meal Preparation		
Toileting		
Walking		
Bathing/Showering		
Dressing		
Household Tasks		

Are you on a special diet? yes no Type: _____

Have you had a change in eating habits in the last year? yes no

Do you use any community resources? (i.e. GECAC, Meals on Wheels, Home Health, etc.) yes no

Gynecologic and Obstetric History

Age of Onset of Periods: _____ Frequency: _____ Length of Period: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Method of Birth Control: _____

Prolonged or Abnormal Bleeding: no yes (please describe) _____

Leakage of Urine: no yes (please describe) _____

Pelvic Pain: no yes (please describe) _____

Abnormal Discharge: no yes (please describe) _____

History of Abnormal Pap Smear: no yes (please describe) _____