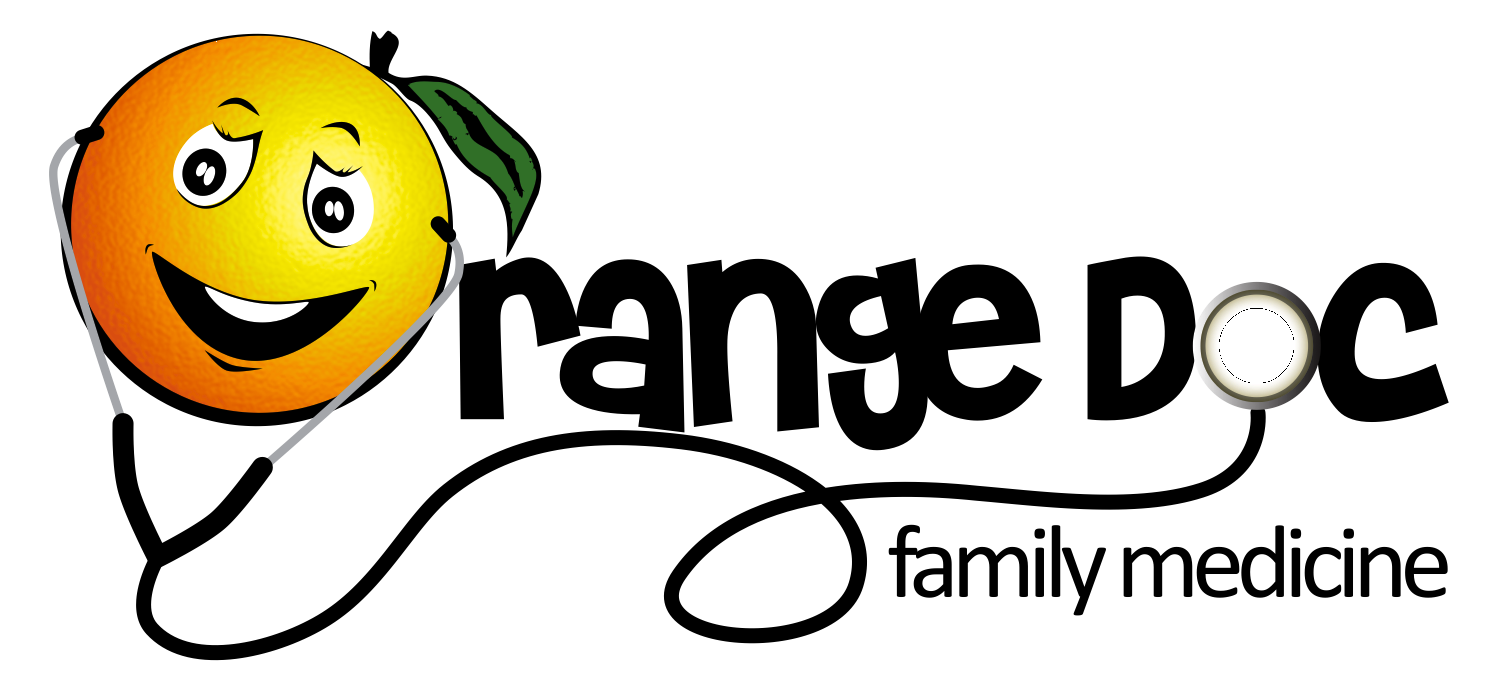
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*835 7th St Suite 5*

*Clermont ,FL 34711*

*Phone: 352-404-8961 Fax: 352-404-8996*

*Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Adult Health History Form .***

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. **Thank You.**

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ How would you rate your general health? □ Excellent □ Good □ Fair □ Poor

**Main reason for today’s visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other concerns:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_ Unexplained weight loss/gain \_\_\_\_ Recent fevers/sweats \_\_\_\_ Unexplained fatigue/weakness \_\_\_\_ Recent chills/cold sweats

*Cardiology*

\_\_\_\_ Chest pains/discomfort \_\_\_\_ Palpitations \_\_\_\_ Decreased exercise tolerance

*Dermatology*

\_\_\_\_ Rash \_\_\_\_ New or change in mole

*Endocrinology*

\_\_\_\_ Cold/heat intolerance \_\_\_\_ Increase thirst/appetite

*ENT*

\_\_\_\_ Change in hearing \_\_\_\_ Congestion \_\_\_\_ Sinus pain \_\_\_\_ Sore throat

*Hematology/Lymph*

\_\_\_\_ Unexplained lumps \_\_\_\_ Easy bruising/bleeding

*Genitourinary*

\_\_\_\_ Painful/bloody urination \_\_\_\_ Leaking urine \_\_\_\_ Nighttime urination \_\_\_\_ Discharge: penis or vagina \_\_\_\_ Concern with sexual functions

*Gastroenterology*

\_\_\_\_ Heartburn/reflux \_\_\_\_ Bloody stools \_\_\_\_ Change in bowel movement \_\_\_\_ Nausea/vomiting/diarrhea \_\_\_\_ Pain in abdomen

*Musculoskeletal*

\_\_\_\_ Muscle/joint pain \_\_\_\_ Recent back pain \_\_\_\_ Weakness \_\_\_\_ Swollen joints

*Neurology*

\_\_\_\_ Memory loss \_\_\_\_ Headaches \_\_\_\_ Fainting \_\_\_\_ Numbness/tingling in hands/feet \_\_\_\_ Loss of balance

*Ophthalmology*

\_\_\_\_ Change in vision \_\_\_\_ Eye pain

*Psychology*

\_\_\_\_ Anxiety/stress \_\_\_\_ Sleep problems

*Respiratory*

\_\_\_\_ Cough/wheeze \_\_\_\_ Coughing blood \_\_\_\_ Short of breath with exertion \_\_\_\_ Pain with breathing

*Women*

\_\_\_\_ No periods \_\_\_\_ Heavy periods \_\_\_\_ Painful periods \_\_\_\_ Irregular periods \_\_\_\_ Unusual vaginal bleeding

Date of last period: \_\_\_\_\_\_\_\_\_\_\_\_ Menopause at age: \_\_\_\_\_\_\_\_\_\_\_\_

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

**MEDICATIONS:** Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication/Vitamin/Supplement; Dose/Strength (e.g., mg/pill) ; How many times per day:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES:** Do you have allergies or reactions to medications? Yes or No (Please Circle one)

Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Foods?** Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMMUNIZATIONS:** Date of most recent record. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Please check all that apply)

Hepatitis A \_\_\_\_\_\_ Hepatitis B \_\_\_\_\_\_ Influenza (flu shot) \_\_\_\_\_\_ MMR \_\_\_\_\_\_ Meningitis \_\_\_ Tetanus (Td) \_\_\_\_\_\_ Varicella (chicken pox) shot or illness \_\_\_\_\_\_

(pneumonia) \_\_\_\_\_\_ Tdap (tetanus & pertussis) \_\_\_\_\_\_

**HEALTH MAINTENANCE:** Date of most recent record. (Please put date near maintenance below)

Cholesterol \_\_\_\_\_\_\_\_\_ Colonoscopy \_\_\_\_\_\_\_\_\_\_\_ Bone Density Scan \_\_\_\_\_\_\_\_\_\_

*Women*: Mammogram \_\_\_\_\_\_ *Men:* PSA (prostate) \_\_\_\_\_\_

**Past MEDICAL HISTORY**

**List any major medical illness previously diagnosed:**

**Heart (Hypertension ,High Cholesterol) :**

**Dermatology/Skin:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Endocrinology(Diabetes, Thyroid) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ENT(Asthma):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Hematology(Blood):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GU/Urinary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Gastro/GI (gastritis, ulcerative colitis, GERD, diverticulitis):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Musculoskeletal(arthritis):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nervous System (depression, anxiety) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SURGICAL HISTORY:**

Year of Surgery

Reason for Surgery

1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY:** Please indicate family members (parent, sibling, grandparent) with any of the following conditions:

Alcoholism, Cancer, Specific Type of Heart disease, Hypertension, Depression/suicide, Genetic disorders , Diabetes, Kidney disease , Liver disease, Glaucoma, Thyroid Disease ,COPD, Asthma, Allergy

**Mother\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Father\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sister\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Brother\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Maternal Grandmother\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Maternal Grandfather\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Paternal Grandmother\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Paternal Grandfather \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY: Tobacco Use:** Cigarettes □ Never. Quit Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Current Smoker: packs/day \_\_\_\_\_ # of yrs \_\_\_\_\_

Other Tobacco: □ Pipe □ Cigar □ Chew

Are you interested in quitting? □ Yes □ No

**Caffeine Intake:** □ None □ Coffee/tea/soda \_\_\_\_\_cups/day

**Weight:** Are you satisfied with your weight? □ Yes □ No

**Diet:** How do you rate your diet? □ Good □ Fair □ Poor. Do you eat or drink four servings of

dairy or soy daily or take calcium supplements? □ Yes □ No

**Exercise:** Do you exercise regularly?□ Yes □ No

What kind of exercise?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long (minutes)\_\_\_\_\_\_\_\_\_\_

How often?\_\_\_\_\_\_\_\_\_\_\_\_\_ If you do not exercise, why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIOECONOMICS:**

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Martial Status: □ Single □ Partner/Married □ Divorced □ Widowed

Number of children/ages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WOMENS HEALTH HISTORY**

# Pregnancies: \_\_\_\_\_\_\_\_\_\_ # Deliveries: \_\_\_\_\_\_\_\_\_\_ # Abortions: \_\_\_\_\_\_\_\_\_\_\_ # Miscarriages:

\_\_\_\_\_\_\_\_\_\_\_ Age at start of periods: \_\_\_\_\_\_ Age at end of periods: \_\_\_\_\_

**Alcohol Use**

Do you drink alcohol? □ Yes □ No # drinks/week \_\_\_\_\_

Is your alcohol use a concern for you or others? □ Yes □ No

**Drug Use**

Do you use any recreational drugs? □ Yes □ No

Have you ever used needles to inject drugs?(Please circle) Yes or No

**Sexual Activity**

Sexually active: □ Yes □ No □ Not currently

Current sex partner(s) is/are: □ male □ female

Birth control method: \_\_\_\_\_\_\_\_\_\_ □ None needed

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

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