

ADULT HEALTH HISTORY
TO BE COMPLETED BY THE PATIENT AND/OR FAMILY

GENERAL INFORMATION:

Today's Date _____
 Name _____ Date of Birth _____
 Address _____
 Phone Number _____ Cell phone number _____
 Height _____ Weight _____

Primary physician _____
 Referring physician _____

Presenting complaint: _____
 Date of onset: _____

Allergies: None

Medication Allergies (list & describe) Food Allergies (list & describe)

SOCIAL HISTORY: Please circle

	How much	How often	Date started	Date quit
Tobacco yes no				
Alcohol yes no				

PAST SURGICAL / PAST MEDICAL HISTORY:-

REPRODUCTIVE HISTORY (female)

Last menstrual period _____
 Are you pregnant? _____