MOUNTAIN VIEW
INTERNAL MEDICINE & PEDIATRICS

ADULT HEALTH HISTORY

CONFIDENTIAL

Name _____ _____ _____
Last First Middle

Age ____ Date of Birth _____ Date of last physical exam _____

What is the reason for today's visit _____

SYMPTOMS – Check (✓) symptoms you currently have or have had in the past year

GENERAL
___ Chills
___ Depression
___ Dizziness
___ Fainting
___ Forgetfulness
___ Headaches
___ Loss of Sleep
___ Loss of weight
___ Nervousness
___ Numbness
___ Sweats

MUSCLE\JOINT\BONE
Pain, weakness, numbness in:
___ Arms ___ Hips
___ Back ___ Legs
___ Feet ___ Neck
___ Hands ___ Shoulders

GENITO-URINARY
___ Blood in urine
___ Frequent urination
___ Lack of bladder control
___ Painful urination

GASTROINTESTINAL
___ Appetite poor
___ Bloating
___ Bowel Changes
___ Constipation
___ Diarrhea
___ Excessive hunger
___ Excessive thirst
___ Gas
___ Hemorrhoids
___ Rectal bleeding
___ Stomach pain
___ Vomiting
___ Vomiting blood

CARDIOVASCULAR
___ Chest pain
___ High blood pressure
___ Irregular heart beat
___ Low blood pressure
___ Rapid heart beat
___ Poor circulation
___ Swelling of ankles
___ Varicose veins

EYE, EAR, NOSE, THROAT
___ Bleeding gums
___ Blurred Vision
___ Crossed eyed
___ Difficulty swallowing
___ Double Vision
___ Earache
___ Ear discharge
___ Hay Fever
___ Hoarseness
___ Loss of hearing
___ Nosebleeds
___ Persistent cough
___ Ringing in the ear
___ Sinus problems
___ Vision – Flashes
___ Vision – Halos

SKIN
___ Bruise easily
___ Hives
___ Itching
___ Changes in moles
___ Rash
___ Scars
___ Sore that won't heal

MEN ONLY
___ Breast lump
___ Erection difficulties
___ Lump in testicles
___ Penis discharge
___ Sore on penis
___ Other

WOMEN ONLY
___ Abnormal Pap Smear
___ Bleeding between periods
___ Breast lump
___ Extreme menstrual pain
___ Hot flashes
___ Nipple discharge
___ Painful intercourse
___ Vaginal discharge
___ Other
Date of last
Menstrual period _____
Date of last
Pap Smear _____
Have you had
a mammogram? _____
Are you pregnant? _____
Number of children _____

CONDITIONS – Check (✓) diagnoses you currently have or have had in the **past year**

___ AIDS
___ Alcoholism
___ Anemia
___ Anorexia
___ Appendicitis
___ Arthritis
___ Asthma
___ Bleeding disorders
___ Breast lump
___ Bronchitis
___ Bulimia
___ Cancer
___ Cataracts
___ Chicken Pox
___ Diabetes
___ Emphysema
___ Epilepsy
___ Glaucoma
___ Goiter
___ Gout
___ Heart Disease
___ Hepatitis
___ Hernia
___ Herpes
___ High Cholesterol
___ HIV positive
___ Kidney disease
___ Liver disease
___ Measles
___ Migraine headaches
___ Miscarriage
___ Mononucleosis
___ Multiple Sclerosis
___ Mumps
___ Pacemaker
___ Psychosocial Issues
___ Pneumonia
___ Polio
___ Prostate problems
___ Psychiatric care
___ Rheumatic Fever
___ Scarlet Fever
___ Stroke
___ Suicide attempt
___ Thyroid problems
___ Tonsillitis
___ Tuberculosis
___ Ulcers
___ Vaginal infections
___ Venereal disease

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FAMILY HEALTH HISTORY – Fill in health information about your immediate family.

Relation	Age	State of Health	Age of Death	Cause of Death	Check (✓) if, your blood relatives had any of the following. Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical dependency	
					Diabetes	
					Heart disease, Strokes	
Sisters					High blood pressure	
					Kidney disease	
					Tuberculosis	
					Other	

HOSPITIZATIONS

Year	Hospital	Reason for Hospitalization and outcome

PREGNANCY HISTORY

Year of birth	Sex of birth	Complications, if any

HEALTH HABITS – check (✓) which substances you use and describe how much you use:

	Exercise	
	Diet	
	Caffeine	
	Tobacco	
	Alcohol	
	Street Drugs	
	Other	

Have you ever had a blood transfusion? ____ Yes ____No

If yes, please give approximate dates _____

SERIOUS ILLNESS\INJURIES	DATE	

MEDICATIONS – List medications you are currently taking	ALLERGIES (medications or substances)