

**COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC.
ADULT HISTORY**

NAME _____	TODAY'S DATE _____
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Please answer the following questions so that we can take better care of you. If you feel that any of the questions are too sensitive to answer on paper, please discuss the answers with your doctor.

REASONS FOR THIS VISIT? What health concerns or symptoms do you have at this time?

1. _____
2. _____
3. _____

PAST AND PRESENT HEALTH

Who was your previous doctor? _____

What other doctors will you continue to see? (Gynecologists, Dermatologists, etc.) Please list names

What were your childhood illnesses? Please circle if you have had any of these: rheumatic fever, polio, measles, mononucleosis, mumps, chicken pox, tuberculosis, asthma, birth defects?

Have you ever been told that you had a medical condition which needed treatment?

(Please circle and write down any details: high blood pressure, diabetes, anemia, heart disease, glaucoma)

What medications are you currently taking which were prescribed by a doctor?

Medicine	Reason	Dose/Strength	How often taken	Date started
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What over the counter medications do you take? (Aspirin, laxatives, antacids, etc.)

Are you ALLERGIC to any medicines? _ Yes _____ No _____

Name of Medication	Type of Allergic Reaction or Problem
_____	_____
_____	_____
_____	_____

GENERAL HEALTH HABITS

Where were you born? _____

Where did you live during childhood? _____

Where have you lived as an adult? _____

What is your present occupation? _____

Have you held jobs with risks like asbestos, radon, or chemical exposure? Yes _____ No _____

Who lives in your household with you? _____

Where do you get your emotional support? _____

What are your sleep habits? _____

What are your exercise habits? _____

How much did you weigh a year ago? _____

Where have you traveled in the last five years? _____

How often do you drink alcohol? _____

What do you usually drink? _____

What is your history of tobacco use? (Cigarettes, pipes, cigars, or chewing tobacco) _____

Do you use any mind-or mood altering drugs not prescribed by a doctor? Yes _____ No _____

What kind? (Heroin, cocaine, LSD, marijuana, skin poppers, other) _____

How often? _____

EDUCATION

List the highest grade of school that you have completed _____

IMMUNIZATIONS

When was your last tetanus shot? _____

Have you had a pneumonia shot and when? _____

OTHER HEALTH CONCERNS

Are you concerned about your exposure to AIDS or HIV virus? (Risk is present when there is a history of blood transfusions, intravenous drug use, homosexuality, multiple sex partners, or a history of sexually transmitted diseases.) Yes _____ No _____

Please answer here if you wish to discuss an Advanced Directive or Living Will with your physician. (An advanced Directive is a Healthcare Power of Attorney or "Living Will" written document which another person whom you choose to make healthcare decisions for you when you are unable. It also permits you to express your wish not to be put on life support.) Yes _____ No _____

Have you ever needed counseling or psychiatric care for emotional problems? Yes _____ No _____

Please list any major reasons why you had to be in the hospital, or operations you have had.

	Type of hospitalization	Date	Complications or problems
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Have you ever received a blood transfusion? Yes _____ No _____

Have you had any complications from transfusions or anesthesia in the past? Yes _____ No _____

SEXUAL HISTORY

Have you ever been told that you had any of the following? If so, was it treated and how? Hepatitis, gonorrhea, syphilis, chlamydia, genital warts, herpes, tuberculosis, AIDS or HIV

In the past 6 months, with how many people have you had sexual contact? (Check one only)

None _____ One _____ 2-4 _____ 5-9 _____ 10 or more _____

What is your current sexual orientation? (Check only one)

Partner(s) of the opposite sex _____ Partner(s) of both sexes _____ Partner(s) of the same sex _____

Have you had sexual contact with anyone of the same sex? Yes _____ No _____

In the past 2 years, which form(s) of sexual contact have you engaged in? (Check all that apply)

Vaginal _____ Oral Genital _____ Anal _____

MAINTAINING YOUR HEALTH

1. Pelvic exam How often _____ Last exam _____

2. Mammogram How often _____ Last exam _____

3. Sigmoidoscopy How often _____ Last exam _____

4. Dental exam How often _____ Last exam _____

WOMEN'S HEALTH

How many times have you been pregnant? _____ How many living children do you have? _____

Have you had any miscarriages? _____ Stillbirths? _____ Abortions? _____

When was your last menstrual period? _____ When was your first menstrual period? _____

Method of Birth Control _____

GENERAL

- Tired easily/weakness
- Marked weight change
- Night sweats
- Fever that won't go away
- Problems with heat
- Recent weight loss

THROAT

- Runny nose
- Soreness
- Hoarseness

EARS

- Loss of hearing
- Ringing in ears
- Discharge

SKIN

- Rash
- Change in nails
- Change in skin color
- Change in hair
- Easy bruising

MOUTH

- Sore gums
- Bleeding gums
- Mouth sores

BREASTS

- Lumps
- Soreness
- Nipple discharge

QUESTIONS/COMMENTS

FAMILY HISTORY - Please check if any relative has had any of the following:

- Anemia
- Leukemia
- Heart disease
- Tuberculosis
- Kidney disease
- Severe allergies
- Seizures
- Thyroid trouble
- Cancer of the bowel
- Bleeding tendency
- Repeated infections
- Chronic lung disease
- High blood pressure
- Asthma
- Mental illness
- Diabetes
- Cancer of the breast
- Skin cancer (melanoma)

EYES

- Eye pain
- Trouble seeing
- Flamed eyes
- Double vision
- Wear glasses
- Problems with cold

NOSE

- Loss of smell
- Frequent colds
- Can't breathe through nose
- Excess nasal discharge
- Nosebleeds

HEART/LUNGS

- Cough that won't go away
- Phlegm
- Bloody phlegm
- Wheezing
- Chest pain or discomfort
- Pain on breathing
- Shortness of breath
- Swelling of ankles
- High blood pressure
- Rapid heart beat
- Vein trouble

MUSCULAR

- Muscle cramps
- Muscle weakness
- Pain in joints
- Swollen joints
- Morning stiffness
- Joint deformity

NERVOUS

- Headaches
- Dizziness
- Fainting
- Seizures
- Nervousness
- Sleeplessness
- Depression
- Memory loss
- Poor coordination
- Paralysis or weakness

URINARY

- Increase in urination
- Unable to hold urine
- Pain during urination
- Blood in urine
- Lack of sex drive
- Pain with intercourse

STOMACH/BOWELS

- Change in appetite
- Difficulty swallowing
- Heartburn
- Belching or excess gas
- Abdominal enlargement
- Nausea
- Vomiting
- Vomiting of blood
- Tarry stools
- Dark urine
- Yellowing of skin
- Constipation
- Diarrhea
- Hemorrhoids

Physician signature: _____

Date: _____

Nursing signature: _____

Date: _____