HOPE CLINIC

ADULT HEALTH HISTORY FORM

PLEASE BRING ALL MEDICATION(S) TO YOUR APPOINTMENT.

Please complete this form and bring it with you to your visit.

Patient ID#: _____

Today's Date: _____

Name: _____ Date of Birth: _____

(Last) (First) (Middle)

Birth Sex: ☐ Male ☐ Female **Current Gender Identity:** ☐ Female ☐ Male ☐ Other

Preferred Pronoun ☐ He, Him, His ☐ She, Her, Hers ☐ They, Them, Theirs ☐ Other _____

☐ Single ☐ Married ☐ Widow(er) ☐ Partner ☐ Divorced **Who do you live with?** ☐ Alone ☐ Partner ☐ Family ☐ Other

Occupation: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Relation to Patient: _____

Having race, ethnicity and language information for all of our patients helps us know them better.

Race: ☐ Alaskan Native or American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

☐ White ☐ Unknown ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Primary Language: ☐ English ☐ Spanish ☐ Other _____

Are there any other languages spoken in the home? If yes, please list:

_____

Preferred Pharmacy: _____

Address: _____

Phone: _____ Fax: _____

Allergies:

Source	Reaction
1.	
2.	
3.	

Surgeries and Hospitalizations: List the approximate date and reason and location for each surgery and hospitalization.

Date/Year	

Do you take your medications as directed? ☐ Yes ☐ No

Please bring all medications to your visit in a bag.

Name of Medication	Dosage	Times Per Day
1.		
2.		
3.		
4.		
5.		
6.		

Supplements / Herbs / Over the counter medication:

1. _____
2. _____
3. _____

Patient Name:_____ **Patient ID#:** _____

Other recent medical or ER visits:

Date	Reason	Where
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History *(Check all that apply)*

Alcohol Use ☐ Yes ☐ No ☐ Former

Years Drinking _____

Drinks per week _____

Type _____

Quit date _____

Last drink _____

Caffeine ☐ Yes ☐ No Amount/week

Coffee _____

Pop/Soda _____

Energy drinks _____

Other: _____

Exercise ☐ Yes ☐ No

Frequency (Hours/week): _____

Types:_____

_____

Please provide any additional information that might be helpful during your visit:

_____

_____

_____

_____

_____

Tobacco ☐ Yes ☐ No ☐ Former

☐ Cigarettes

Packs per day _____

☐ Cigars ☐ Chewing Tobacco

☐ Other: _____

☐ Would like to quit

Years of use _____

Year quit _____

Sexual History

Are you currently sexually active?

☐ Yes ☐ No

Any history of sexually transmitted diseases?

☐ Yes ☐ No

If yes, when?

Recreational drug use

☐ Yes ☐ No ☐ Former

Marijuana:

☐ Yes ☐ No ☐ Former

Other:

☐ Yes ☐ No ☐ Former

Have you ever used IV drugs?

☐ Yes ☐ No

Personal safety

Do you wear your seatbelt?

☐ Yes ☐ No

Have you experienced a fall in the last year?

☐ Yes ☐ No

If yes, how many falls this year? _____

Are you afraid of anyone? ☐ Yes ☐ No

Has anyone hurt you physically?

☐ Yes ☐ No

Has anyone hurt you sexually?

☐ Yes ☐ No

Do you need help now?

☐ Yes ☐ No

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly daily

Feeling down, depressed or hopeless ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly daily

Do you have a Living Will/Durable Power of Attorney? ☐ Yes ☐ No

Patient Signature _____ Date: _____

Physician Signature: _____ Date: _____

Patient Name:_____

Patient ID:_____

Personal and Family History

☐ Unknown/Adopted

(Check all that apply)

Circle any items that were known cause of death for relative

MEDICAL CONDITION	SELF	RELATIVE	WHICH RELATIVE
ADD/ADHD	☐ Yes	☐ Yes	_____
Alcoholism	☐ Yes	☐ Yes	_____
Allergies	☐ Yes	☐ Yes	_____
Alzheimer's Disease/Dementia	☐ Yes	☐ Yes	_____
Anemia	☐ Yes	☐ Yes	_____
Anxiety	☐ Yes	☐ Yes	_____
Arthritis	☐ Yes	☐ Yes	_____
Asthma	☐ Yes	☐ Yes	_____
BPH (enlarged prostate)	☐ Yes	☐ Yes	_____
Blood clots	☐ Yes	☐ Yes	_____
Blood disease (visits to hematology)	☐ Yes	☐ Yes	_____
Cancer(s):			
Breast	☐ Yes	☐ Yes	_____
Colon	☐ Yes	☐ Yes	_____
Lung	☐ Yes	☐ Yes	_____
Prostate	☐ Yes	☐ Yes	_____
Other _____	☐ Yes	☐ Yes	_____
CVA (Stroke or TIA)	☐ Yes	☐ Yes	_____
Colon Problems	☐ Yes	☐ Yes	_____
COPD (emphysema)	☐ Yes	☐ Yes	_____
Dental Problems	☐ Yes	☐ Yes	_____
Depression	☐ Yes	☐ Yes	_____
Developmental Delay	☐ Yes	☐ Yes	_____
Diabetes	☐ Yes	☐ Yes	_____
Gallbladder Disease	☐ Yes	☐ Yes	_____
GERD/Acid Reflux	☐ Yes	☐ Yes	_____
Glaucoma/Cataracts	☐ Yes	☐ Yes	_____
Hearing Problems	☐ Yes	☐ Yes	_____
Heart disease/problems	☐ Yes	☐ Yes	_____
Angina	☐ Yes	☐ Yes	_____
Atrial Fibrillation	☐ Yes	☐ Yes	_____
Heart Attack	☐ Yes	☐ Yes	_____
Hemorrhoids	☐ Yes	☐ Yes	_____
Hernia	☐ Yes	☐ Yes	_____
Hepatitis C	☐ Yes	☐ Yes	_____
Hyperlipidemia (high cholesterol)	☐ Yes	☐ Yes	_____
Hypertension (high blood pressure)	☐ Yes	☐ Yes	_____
Injuries (severe):	☐ Yes	☐ Yes	_____
Concussion or head injury	☐ Yes	☐ Yes	_____
Car/motorcycle accident injury	☐ Yes	☐ Yes	_____
Broken bones?	☐ Yes	☐ Yes	_____
Which ones?	☐ Yes	☐ Yes	_____
_____			
Any other injuries:	☐ Yes		
_____			
_____			

MEDICAL CONDITION	SELF	RELATIVE	WHICH RELATIVE
Irritable bowel disease	☐ Yes		☐ Yes
Kidney disease	☐ Yes		☐ Yes
Kidney stones	☐ Yes		☐ Yes
Learning disability	☐ Yes	☐ Yes	_____
Liver disease/Hepatitis	☐ Yes	☐ Yes	_____
Lupus	☐ Yes	☐ Yes	_____
Mental Illness	☐ Yes	☐ Yes	_____
Migraines/headaches	☐ Yes	☐ Yes	_____
Obesity	☐ Yes	☐ Yes	_____
Osteoporosis	☐ Yes	☐ Yes	_____
Peptic ulcer disease	☐ Yes	☐ Yes	_____
Peripheral vascular disease	☐ Yes	☐ Yes	_____
Seizure disorder/Epilepsy	☐ Yes	☐ Yes	_____
Skin problems	☐ Yes	☐ Yes	_____
Sleep Apnea	☐ Yes	☐ Yes	_____
Thyroid disease	☐ Yes	☐ Yes	_____
OTHER (please list)			
_____	☐ Yes	☐ Yes	_____
_____	☐ Yes	☐ Yes	_____

Have you had the following illnesses or vaccines?

Check all that apply	Date
☐ COVID	_____
☐ Hepatitis A	_____
☐ Hepatitis B	_____
☐ HPV (Gardasil)	_____
☐ Influenza	_____
☐ Last tetanus vaccination	_____
☐ Pneumonia (Pneumovax)	_____
☐ Pneumonia (Prevnar)	_____
☐ Shingles (Zostavax)	_____

SCREENING

Have you had a colonoscopy ? ☐ Yes ☐ No

If yes, when? _____

FOR WOMEN ONLY

How many: Pregnancies_____Live births _____

Menstrual History:

Do you use any form of birth control? ☐ Yes ☐ No

If yes, what?_____

First day of last menstrual period _____

Screening Tests **Date**

Last pap smear: _____

Any abnormal pap smears and/or cervical procedures?

☐ Yes ☐ No If yes, indicate results and date.

Mammogram: _____

Any abnormal mammograms?

☐ Yes ☐ No If yes, indicate results and date.