MOUNTAINSTAR
Jordan Family Health
affiliated with St. Mark's Hospital

Name _____ ***Date*** _____

Date of birth _____

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.

How would you rate your general health? ***Please circle one:*** ***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
- _____ Nightime urination
- _____ Discharge: penis or vagina
- _____ Concern with sexual functions

Gastroenterology
- _____ Heartburn/reflux
- _____ Bloody stools
- _____ Change in bowel movement
- _____ Nausea/vomitting/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

Opthalmology
- _____ Change in vision
- _____ Eye pain

Psychology
- _____ Anziety/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:

Medication	*Reaction*	*Food*	*Reaction*

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Patient Name: _____ **Today's Date:** _____

Date Of Birth: _____

Medical History:

	Yes	No	Comments		Yes	No	Comments		Yes	No	Comments
Allergies				Depression				Heart Attack			
Anemia				Diabetes				Nerve / muscle disease			
Anxiety				Emphysema				Osteoporosis			
Arthritis				Reflux				Seizures			
Asthma				Glaucoma				Sickle cell anemia			
Blood transfusion				Heart murmur				Stroke			
Cancer				HIV/AIDS				Drug or Alcohol abuse			
High Blood Pressure				Thyroid disease				Congestive Heart Failure			
Kidney disease				Tuberculosis				Blood Clots			
Meningitis				Ulcers							
Other:											

Surgical History:

	Yes	No	Comments		Yes	No	Comments		Yes	No	Comments
Appendectomy				C-Section				Prostate surgery			
Brain surgery				Eye surgery				Small intestine surgery			
Breast surgery				Fracture surgery				Spine surgery			
Heart Bypass Surgery				Hernia repair				Tubal ligation			
Gallbladder Removal				Hysterectomy				Valve replacement			
Colon surgery				Joint replacement				Vasectomy			
Cosmetic surgery											
Other:											

Family History:

Relationship	Alive or Deceased	Alcohol Abuse	Alzheimers	Arthritis	Asthma	Birth Defects	Cancer	Emphysema	Depression	Diabetes	Drug Abuse	Early Death	Hearing Loss	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Learning Disabilities	Mental Illness	Mental Retardation	Miscarriages	Stroke	Vision Loss
Mother																							
Father																							
Sister																							
Brother																							
Daughter																							
Son																							
Maternal Aunt																							
Maternal Uncle																							
Paternal Aunt																							
Paternal Uncle																							
Maternal Grandmother																							
Maternal Grandfather																							
Paternal Grandmother																							
Paternal Grandfather																							

Social History:

	Type	Yes		No
Alcohol Use				
Sexually Active	n/a			
Drug Use				
Tobacco Use				
Number of Years				
# Packs Per Day				