

ADULT HISTORY RECORD - Confidential

PERSONAL HISTORY

Your Name _____ Male Female Date of Birth ____/____/____

Person to contact in an emergency _____ Relationship to you _____

Their work phone (____) _____ Their home phone (____) _____

MARITAL HISTORY: Married # years _____ Last grade completed or degree obtained: _____ Religious preference: _____
 # times _____

Single ALCOHOL USE: Never TOBACCO USE: _____
 Separated Occasional Number of years _____
 Divorced Weekends Packs per day _____
 Widowed Daily

WORK HISTORY: Currently working? Yes List types of work you have been involved in: _____
 No _____
 Retired _____
 Homemaker _____

I was referred by _____

ILLNESSES

Check where you or members of your family have had the following illnesses or problems:

You	Your Family	
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, tumor
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Drug abuse
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Eczema, hives, rashes
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy, seizures
<input type="checkbox"/>	<input type="checkbox"/>	Eye problems
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder problems
<input type="checkbox"/>	<input type="checkbox"/>	Liver disease, hepatitis, yellow jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Lung disease, tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Mumps, measles, chicken pox
<input type="checkbox"/>	<input type="checkbox"/>	Nervous breakdown, mental illness
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	Rubella, German measles
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer in stomach, duodenum
<input type="checkbox"/>	<input type="checkbox"/>	Uncontrolled bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Veneral disease
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

MEDICINES

Include birth control pills or vitamins, with or without a prescription:

ALLERGIES

Drugs and other allergies:

IMMUNIZATIONS

Measles shot _____
 Tetanus shot _____
 Pneumonia shot _____
 Flu shot _____

HOSPITALIZATIONS

Serious illness, injuries or surgeries and year. Do not list normal pregnancies.

PREGNANCY HISTORY Enter number of times _____ Premature _____

Miscarriages _____ Abortions _____ Live Births _____ Living children _____

HEALTH CARE PROVIDERS

List physicians you have seen in the past five years.

Year	Name	City, State	Problem cared for
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____