

ADULT HEALTH HISTORY



Patient Name	Date of Birth	Date Today
Medications taken regularly (include doses)		
Allergies to Medications		
Ongoing Medical Problems		
Previous Surgeries		
Occupation	Marital Status	

Immunizations and Personal Habits

	Yes	No	Date		Yes	No	Amount / Frequency
Flu				Smoke			
Pneumonia (Pneumococcal-23)				Drink Alcohol			
Pneumonia (Pevnar-13)				Street Drugs			
Tetanus (Td)				Marijuana			
Tetanus-Diphtheria-Pertussis (TDaP)				Exercise			
Shingles (Zoster Vaccine)				Drink Coffee/Cola			
Allergic reactions to vaccine(s)?							
If yes, which vaccine(s)?							

Preventive Screening History

	Date		Yes	No	Date
Last Colonoscopy		Last Pap Smear	Abnormal?		
Performed by:		HPV testing	Abnormal?		
Last Bone Density testing		Performed by:			
Performed by:		Hysterectomy	Cervix removed?		
Last Abdominal Aorta Aneurysm (AAA) Screening		Performed by:			
Performed by:		Last Mammogram	Abnormal?		
		Performed by:			

Patient Signature
