Fishers Family Care Health History Form
Adult

Patient Name:	DOB:	Today's Date:
Current Medications:		
Allergies:		
Surgeries/Hospitalizations/Major Illnesses (include age and/or date):		

Patient Medical History
(check any past/current patient problems)

- ☐ confused
- ☐ unresponsive
- ☐ eyes
- ☐ ears
- ☐ nose
- ☐ mouth
- ☐ sinus
- ☐ throat
- ☐ skin problems
- ☐ rash
- ☐ hives
- ☐ hearing
- ☐ speech
- ☐ vision
- ☐ loose or chipped teeth
- ☐ capped or false teeth
- ☐ stomach problems
- ☐ weight loss
- ☐ weight gain
- ☐ bowel problems
- ☐ liver problems/hepatitis
- ☐ gallbladder
- ☐ bladder
- ☐ kidney
- ☐ dialysis
- ☐ abnormal pap smears
- ☐ problems with reproductive organs
- ☐ circulation problems
- ☐ blood clots
- ☐ bleeding
- ☐ high blood pressure
- ☐ stroke
- ☐ heart problems
- ☐ thyroid
- ☐ diabetes
- ☐ immune system problems
- ☐ bones
- ☐ difficulty walking
- ☐ frequent falls
- ☐ seizures
- ☐ weakness
- ☐ too little sleep
- ☐ too much sleep
- ☐ lung problems
- ☐ breathing problems
- ☐ chronic cough
- ☐ tuberculosis (TB)
- ☐ positive TB skin test
- ☐ pain; location__________
- ☐ cancer, location________
- ☐ other _________________

☐ implants/surgical or other metal inside the body ; type ______________________ location ______________________
☐ problems with anesthesia, describe ____
Explain any check items: ____
____
Date of pneumonia shot___________ last tetanus shot ___________ last flu shot ___________ last TB skin test _____________

Family History

Father: ☐ living ☐ deceased age at death ______ cause of death____
Mother: ☐ living ☐ deceased age at death ______ cause of death ____

Have you had a family member with any of the following? If so, check the appropriate box and write the family member.

- ☐ Asthma _______________________
- ☐ Emphysema ___________________
- ☐ Epilepsy _____________________
- ☐ Diabetes _____________________
- ☐ Tuberculosis __________________
- ☐ Stroke ________________________
- ☐ Febrile Seizures _______________
- ☐ Thyroid Disease _______________
- ☐ Heart Diseases/Attack ___________
- ☐ Mental Retardation _____________
- ☐ Genetic Disease ________________
- ☐ Cancer (include type)____________
- ☐ Bleeding Disorders ____________
- ☐ SIDS (crib death) ______________
- ☐ High Blood Pressure ____________
- ☐ High Cholesterol _______________
- ☐ Other ________________________ ________________________________

Do you have an advance directive? ☐ No ☐ Yes If yes, ☐ living will ☐ durable power of attorney ☐ health care directive

Social History

Marital Status: ____________ Children's (list names):____
Do you live alone ☐ Yes ☐ No If you needed help to care for yourself; is there someone available to help you? ☐ Yes ☐ No
Do you use tobacco? ☐ No ☐ Yes If yes, how much/ day_________ How long? ___________________________
Do you use recreational drugs? ☐ No ☐ Yes If yes, what type? ________________ How long? _______________
Do you use alcohol? ☐ No ☐ Yes If yes, how much per day? __________ Per week? __________ How long? __________
Do you use caffeine? ☐ No ☐ Yes If yes, how much per day? ___________ How long? _____________
Do you exercise routinely? ☐ Yes ☐ No
Unusual dietary habits or herbal supplements:____

Signature ______________________________________ Relationship to patient____________________ Date ______________