WFMA
Waynesboro Family Medical Associates, LLP

ADULT HEALTH HISTORY

(Use for ages 21 and over)

Your answers on this form will help your provider understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank You.**

Patient Name:______________________ Today's Date: ____________

Date of Birth: ________ Age: _____ How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Main reason for today's visit: ______________________

Other concerns I would like to discuss today: ______________________

REVIEW OF SYSTEMS Please check any CURRENT symptoms you have.

General
- _____ Recent fevers/sweats
- _____ Unexplained weight loss/gain
- _____ Unexplained tiredness/weakness

Eyes
- _____ Change in vision

Ears/Nose/Throat/Mouth
- _____ Difficulty hearing/ringing in ears
- _____ Hay fever/allergies/congestior
- _____ Trouble swallowing

Heart/Cardiovasvular
- _____ Chest pains/discomfort
- _____ Palpitations
- _____ Short of breath with activity

Breast
- _____ Breast lump
- _____ Nipple discharge

Lungs/Respiratory
- _____ Cough/wheeze
- _____ Coughing up blood

Gastrointestinal
- _____ Heartburn/reflux
- _____ Blood or change in bowel movements
- _____ Nausea/vomiting/diarrhea
- _____ Pain in abdomen

Genitourinary
- _____ Painful/bloody urination
- _____ Leaking urine/weak urine stream
- _____ Nighttime urination
- _____ Discharge: penis or vagina
- _____ Unusual vaginal bleeding
- _____ Cocern with sexual function

Musculoskeletal
- _____ Muscle/joint pain
- _____ Recent back pain

Skin
- _____ Rash
- _____ New or change in mole

Neurological
- _____ Headaches
- _____ Memory loss
- _____ Fainting/falling

Psychiatric/Emotional
- _____ Anxiety/stress
- _____ Sleep problems

Blood/Lymph
- _____ Unexplained lumps
- _____ Easy bruising/bleeding

Endocrine
- _____ Cold/heat sensitive
- _____ Increased thirst/appetite

In the past month, have you had little interest in doing things, or felt down, depressed or hopeless? ☐ Yes ☐ No

CURRENT MEDICATIONS Please list **all** medicines, vitamins, home remedies, birth controll pills, herbs, etc.

Medication	Dose (mg/pill)	Times/day	Medication	Dose (mg/pill)	Times/day

ALLERGIES or reactions for medications: ______________________

Date of your most recent **IMMUNIZATIONS:** Influenza (flu shot) ______ Pneumovax (pneumonia) ______ Tetanus (Td) ______
Tdap (tetanus & pertussis)______ Hepatitis A ______ Hepatitis B ______ MMR ______ Meningitis ______

Signature of person completing this form: ______________________

Reviewed by Provider: ______________________

ADULT HEALTH HISTORY

Patient Name: ______________________________ Date: __________

PERSONAL MEDICAL HISTORY:

Please note if you have had any of the following medical problems

_____ Heart disease:
Specify type: ______________
_____ Heart attack
_____ Asthma/lung disease

_____ High blood pressure
_____ Diabetes
_____ Cancer (type) ______________
_____ Other (specify) ______________

_____ High cholesterol
_____ Thyroid problem
_____ Kidney disease
_____ Birth defects

SURGICAL HISTORY:

Please list all prior operations (with dates)

FAMILY HISTORY:

Please note family members (mother, father, sister, brother, aunt, uncle, grandparent)

Alcoholism ______________
Cancer (type) ______________
Heart disease ______________
Depression/suicide ______________
Genetic disorders ______________
Diabetes ______________

High cholesterol ______________
High blood pressure ______________
Stroke ______________
Bleeding/clotting disorder ______________
Asthma/COPD ______________
Other ______________

SOCIAL HISTORY:

Tobacco use: ☐ Never ☐ Quit date: __________
☐ Current smoker: packs/day____ # of years____
Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
Plan to quit? ☐ Now ☐ Sometime later ☐ No/never

Alcohol use:
Do you or any household members drink alcohol?
☐ No ☐ If Yes, who? __________ ☐ Socially
drinks/week __________

Drug Use/Addiction:
Do you or any household members use illegal drugs?
☐ No ☐ If Yes, who? __________
Name of drug? __________
Does anyone in your household have an addiction to a drug or perscription medication?
☐ No ☐ If Yes, who? __________
Name of drug/medication __________

OTHER CONCERNS:

Caffeine Use: ☐ None ☐ Coffee/tea/soda ______cups/day
Weight: Are you satisfied with your weight? ☐ No ☐ Yes
Diet: How do you rate your diet? ☐ Good ☐ Fair ☐ Poor
Exercise: Do you excercise regularly? ☐ No ☐ Yes, how often? ______
What kind of exercise? __________ Minutes per day? ______
If you do not exercise, why? __________
Safety: Do you use a bike/motorcycle helmet? ☐ NA ☐ No ☐ Yes
Do you regularly wear seatbelts? ☐ No ☐ Yes
Is there violence in the home? ☐ No ☐ Yes
Have you ever been abused? ☐ No ☐ Yes
Do you have a gun in your home? ☐ No ☐ Yes
Sexual Activity:
Sexually active? ☐ No ☐ Yes ☐ Not currently
Current sex partner(s) is/are: ☐ Male ☐ Felmale
Birth control method ________ ☐ None needed
Have you ever had any sexually transmitted diseases? (STD's) ☐ No ☐ Yes, __________
Interested in being screened for STD's? ☐ No ☐ Yes

Do you have a completed living will or power of attorney for health care? No Yes

Signature of person completing this form: ______________________________
Reviewed by Provider: ______________________________

ADULT HEALTH HISTORY

Patient Name: ______________________________ Date: __________

HEALTH MAINTENANCE/SCREENING TESTS:

General: Yearly dental visits? ☐ No ☐ Yes Date of last dental checkup? __________ ☐ Unknown

Do you take Calcium? ☐ No ☐ Yes Do you take Aspirin? ☐ No ☐ Yes

Have you had any of the following tests? Select each box that applies and enter date and result of most recent test.

☐ lipid (cholesterol) test Date: __________ Abnormal? ☐ No ☐ Yes

☐ Sigmoidoscopy or Colonoscopy Date: __________ Abnormal? ☐ No ☐ Yes

☐ Stool for occult blood (3 samples) Date: __________ Abnormal? ☐ No ☐ Yes

Men: ☐ PSA (prostate) Date: __________ Abnormal? ☐ No ☐ Yes

Woman: ☐ Mammogram Date: __________ Abnormal? ☐ No ☐ Yes

☐ Clinical breast exam Date: __________ Abnormal? ☐ No ☐ Yes

☐ Pap smear Date: __________ Abnormal? ☐ No ☐ Yes

☐ Dexascan/bone density Date: __________ Abnormal? ☐ No ☐ Yes

Age at start of periods: ______ First day of last menstrual period: __________ Age at end of periods: ________

Do you have problems with your period or birth control? ☐ No ☐ Yes. ______________________

List number of pregnancies: _____ Deliveries: _____ Abortions/miscarriages: _____ Living children/ages: _______

If post menopause or over age 50, do you take:

Calcium? ☐ No ☐ Yes Estrogen? ☐ No ☐ Yes Progesterone? ☐ No ☐ Yes

SOCIAL/ECONOMIC: Occupation: ____________________ Employer: ____________________

Highest year of education: __________ Marital status: ☐ Single ☐ Married/partnered ☐ Divorced ☐ Widowed ☐ Other

Spouse/Partner's name: ____________________ Number of children (ages): ____________________

Who lives at home with you? ____

____

Signature of person completing this form: ______________________________

Reviewed by Provider: ______________________________