WHOLE FAMILY INTEGRATIVE Adult Health History

Patient Name DOB

_____

Medications: (prescription, over the counter, herbs, vitamins, etc.)

Drug Name Dose

_____

_____

_____

Allergies to Medications, X-ray Dyes or other Substances. Yes { } No { } (Name Med & Reaction)

Past Medical History: Do you have any of the following? Please circle all that apply:

ASTHMA BRONCHITIS CANCER DIABETES EMPHYSEMA HEART DISEASE HYPERTENSION SEIZURES

KIDNEY DISEASE SEASONAL ALLERGIES PLEASE LIST ANY MEDICAL CONDITIONS NOT LISTED: _____

_____

Surgeries: (please List)_____

Immunizations: (approximate dates)

Pneumonia _____ TDap _____TD_____Flu_____

Family History: Has **any** member of your family (parents, siblings, children) ever had any of the following?

Illness	family member(Maternal/Paternal)
Cancer (type)	
High Blood Pressure	
Diabetes	
Heart Disease	
Seizures	
Osteoporosis	
Other	

Safety:

Do you wear seatbelts? ☐Yes ☐No

Do you wear a helmet? ☐Yes ☐No

Do you use your phone while driving? ☐Yes ☐No

Do you wear protective sports gear? ☐Yes ☐No

Does your house have a working smoke detector? ☐Yes ☐No

If you have guns at home, are they locked up? ☐Not applicable ☐Yes ☐No

Is violence at home a concern for you? ☐Yes ☐No

Household Exposure: Concerns about lead exposure? (Old home, Plumbing, Peeling Paint) □Yes □No

Tobacco Use: Smoke cigarettes: □Yes □No □Never Other house members smoke? □Yes □No

Quit date: _____ How many years did you smoke?_____

Substance Use: Have you ever used any illegal drugs/substances? □Yes □No Type: _____

Alcohol Use: Do you drink alcohol? □Social □Occasional □Light □Heavy

Diet: Type of diet?_____ **Exercise:** □Yes □No Type:_____ Frequency:_____

Caffeine Use: (How many cups/day) Coffee: ____Tea: _____ Energy Drink:_____Soda:_____Chocolate:_____

Sleep: Hours of sleep/night: _____ Naps/Duration? _____ Any Sleeping Issues?_____

Dental: How often do you brush your teeth?_____ Date of last dentist visit: _____

Vision: Do you wear? □Reading Glasses □Prescription Glasses □ Contacts Date of last Eye Exam: _____

Hearing: When was your last hearing test?_____ Do you wear a hearing aid? □Yes □No

Travel: Have you recently traveled outside of the country? □Yes □No When/Where?_____

Hobbies: What activities do you do for fun or to relax?_____

Life Stressors: Have you had any life changes in the last year?_____

Sexual History: Sexually involved currently: □Yes □No Sexual partner(s) is/are/have been: □ Male □Female

Birth Control Method (check all that apply): □None needed □condom □pill □diaphragm □vasectomy

Social History:

Occupation (or prior): _____ retired/unemployed/LOA/disabled/Military (circle one)

Employer: _____Years of education/highest degree: _____

Marital status (circle one): Single, Partner, Married, Divorced, Widowed.

Spouse/ Partners name:_____ Number of children:_____ Pets?_____

Women Health History:

Total number of pregnancies:_____ Total Number of births: _____

Date of last menstrual period: _____ Frequency:_____

Age onset menstruation: _____ Age at menopause: _____

Patient Signature: _____ Date: _____