GVH GRAND VIEW HEALTH

Grand View Medical Practices Adult Health History Form

Name _____ Date of Birth _____

Main reason for today's visit _____

Other concerns _____

What are your health goals for the next year? _____

Where were you receiving care before? _____

When were you last seen? _____

Check any **persistent** symptoms you have had in the **past few months**:

- ☐ Unexplained weight change
- ☐ Heat/cold sensitivity
- ☐ Fall asleep during the day when sitting
- ☐ New/changed mole
- ☐ Breast lump/pain/discharge
- ☐ Nose bleeds
- ☐ Hoarseness
- ☐ Hearing Problems
- ☐ Vision changes
- ☐ Chest pain
- ☐ Anxiety/stress
- ☐ Shortness of Breath
- ☐ Cough/wheeze
- ☐ Heartburn/reflux
- ☐ Blood in stool
- ☐ Change in bowel
- ☐ Frequent urination
- ☐ Leaking urine
- ☐ Blood in urine
- ☐ Vaginal/Penile discharge
- ☐ Concern w/ sexual function
- ☐ Frequent crying
- ☐ Back pain
- ☐ Joint pain
- ☐ Swollen gland
- ☐ Easy bruising
- ☐ Headache
- ☐ Memory loss
- ☐ Fainting
- ☐ Dizziness
- ☐ Balance issues
- ☐ Frequent falls
- ☐ Sleep trouble

Women Only:

- ☐ Premenstrual symptoms (bloating, cramping, irritability)
- ☐ Problems with menstrual periods
- ☐ Hot flashes/night sweats

Past Medical History:

- ☐ Anemia
- ☐ Asthma
- ☐ Allergy
- ☐ Alcohol/Drug Addiction
- ☐ Anxiety
- ☐ Arthritis
- ☐ Bowel Disease
- ☐ Bladder Problems
- ☐ Blood Clot
- ☐ Cancer Type _____
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ high Cholesterol
- ☐ HIV
- ☐ Headaches
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Osteoporosis
- ☐ Prostate Problem
- ☐ Seizure Disorder
- ☐ Sexually Transmitted Disease
- ☐ Skin Condition
- ☐ Sleep Apnea
- ☐ Thyroid Disorder
- ☐ Psychiatric Disease
- ☐ Stroke
- ☐ Ulcer Disease

Past Surgical History: Please list all surgeries with approximate date:

Surgery	Date

Grand View Medical Practices Adult Health History Form (continued)

Name _____ Date of Birth _____

Hospitalizations other than surgery. Please list with approximate dates:

Hospitalization	Date

Family History: Has any family member had the following: **(Please list age at diagnosis.)**

Mom	Age	Dad	Age	Sibling	Age	Grandparent	Age	
☐		☐		☐		☐		Alzheimer's
☐		☐		☐		☐		Asthma
☐		☐		☐		☐		Autoimmune Disease
☐		☐		☐		☐		Aneurysm
☐		☐		☐		☐		Bleeding/clotting Disease
☐		☐		☐		☐		Brain Tumor
☐		☐		☐		☐		Cancer (List type of cancer)
☐		☐		☐		☐		Colon Polyp
☐		☐		☐		☐		Diabetes
☐		☐		☐		☐		Depression/Anxiety
☐		☐		☐		☐		Glaucoma
☐		☐		☐		☐		Heart Disease (e.g. heart attack)
☐		☐		☐		☐		Hypertension
☐		☐		☐		☐		Lung Disease
☐		☐		☐		☐		Multiple Sclerosis
☐		☐		☐		☐		Osteoporosis
☐		☐		☐		☐		Stroke
☐		☐		☐		☐		Seizures
☐		☐		☐		☐		Drug/alcohol Abuse
☐		☐		☐		☐		Genetic Disorder (explain)

Health Maintenance Screening:

		Normal	Abnormal
Lipid (cholesterol)	Date _____	☐	☐
Colonoscopy	Date _____	☐	☐
Eye Exam	Date _____	☐	☐

Immunizations:

HPV (cervical cancer)	Date _____
Influenza	Date _____
Tetanus/Pertussis	Date _____
Hepatitis B	Date _____
Pneumonia	Date _____

Women Only:

Mammogram Date _____
Any abnormal mammograms? ☐ Yes ☐ No
Pelvic/Pap Date _____
Have you ever had an abnormal PAP? ☐ Yes ☐ No
Bone Density Test Date _____

Grand View Medical Practices Adult Health History Form (continued)

Name _____ Date of Birth _____

Social History:

Who lives in your home with you? _____
Leisure activities, group involvement, volunteer work, recent travel: _____
_____
What is your occupation? _____
Do you drink alcohol? ☐Yes ☐No If yes, how many/week? _____
Do you smoke? ☐Yes ☐No If yes, how many/day?_____ Number of years?_____
If quit, quit date. _____ How many years did you smoke? _____
Other tobacco: ☐pipe ☐cigar ☐chew ☐snuff
Do you consume caffeine? ☐Yes ☐No If yes, how many cups/day? _____
Do you use recreational drugs? ☐Yes ☐No If yes, what type/how often? _____
Have you ever used needle to inject drugs? ☐Yes ☐No
Sexually active currently? ☐Yes ☐No How many partners? _____
Sexual partner is/are/have been: ☐male ☐female
Current birth control: ☐condoms ☐pill ☐diaphragm ☐vasectomy ☐IUD ☐Nuva ring
☐abstinence ☐Other (please explain) _____
Do you ever feel afraid at home? ☐Yes ☐No Have you been physically hurt by your partner? ☐Yes ☐No
If yes, would you like information on sources of help? ☐Yes ☐No
Do you have guns in your home? ☐Yes ☐No If yes, are they locked up? ☐Yes ☐No
Do you wear seat belts? ☐Yes ☐No If no, why? _____
Do you use a bike helmet if you ride a bike? ☐Yes ☐No If no, why? _____
Do you have a working smoke detector in your home? ☐Yes ☐No
Do you exercise regularly? ☐Yes ☐No What kind of exercise? _____
How long (minutes)? _____ How often? _____
How do you rate your diet? ☐Good ☐Fair ☐Poor
Would you like advice on your diet? ☐Yes ☐No
Do you have a living will or advanced directive? ☐Yes ☐No

Women Only:

# of pregnancies _____ Any complications? _____
Live births _____ # Still births _____ # Miscarriages _____ # Terminations _____
Premature births (less than 36 weeks) _____ # Live children _____
Date of last menstrual period _____
Age at first period _____ Age at end of periods (menopause): _____

Allergies to Medication:

_____ _____

_____ _____

Medications (prescribed, over the counter, vitamins, herbs, etc)

Drug/Dose	Frequency	Reason Taken