Adult History Form **Rienstra Clinic** Today's Date _____

Name:_____ Date of Birth _____

Male __ Female __ Domestic status _____ Education _____

Active, Current Problems:

_____
_____
_____
_____
_____
_____
_____

Past Problems and Hospitalizations:

_____
_____
_____
_____
_____
_____

Surgeries, Procedures (include transfusions):

_____
_____
_____
_____
_____
_____

Medications (please include Vitamins and Supplements)

Current :

_____
_____
_____
_____
_____
_____
_____
_____

Past :

_____
_____
_____
_____
_____
_____
_____

Allergies:

To Medicines:

_____
_____
_____
_____
_____

Other:

Preferred Pharmacy: _____

Family History: Unknown (adopted) _____

	Father	Mother	Brother	- sister	Bro/sis	Bro/sis	Child	Child	Grandparents (MGF, MGM; PGF, PGM)
Healthy ……	_____	_____	_____	_____	_____	_____	_____	_____	
Birth year	_____	_____	_____	_____	_____	_____	_____	_____	
Life span if deceased	_____	_____	_____	_____	_____	_____	_____	_____	
High blood pressure	_____	_____	_____	_____	_____	_____	_____	_____	_____
Diabetes ……..	_____	_____	_____	_____	_____	_____	_____	_____	_____
Heart disease ……..	_____	_____	_____	_____	_____	_____	_____	_____	_____
High Cholesterol…..	_____	_____	_____	_____	_____	_____	_____	_____	_____
Sudden death ……..	_____	_____	_____	_____	_____	_____	_____	_____	_____
Stroke…….	_____	_____	_____	_____	_____	_____	_____	_____	_____
Cancer ……..	_____	_____	_____	_____	_____	_____	_____	_____	_____
Kidney Disease…….	_____	_____	_____	_____	_____	_____	_____	_____	_____
AIDS ……..	_____	_____	_____	_____	_____	_____	_____	_____	_____
Asthma……..	_____	_____	_____	_____	_____	_____	_____	_____	_____
Emphysema/Lung…	_____	_____	_____	_____	_____	_____	_____	_____	_____
Hay Fever/Allergies..	_____	_____	_____	_____	_____	_____	_____	_____	_____
TB ……..	_____	_____	_____	_____	_____	_____	_____	_____	_____
Suicide ……..	_____	_____	_____	_____	_____	_____	_____	_____	_____
Alcoholism ……	_____	_____	_____	_____	_____	_____	_____	_____	_____
Obesity ……..	_____	_____	_____	_____	_____	_____	_____	_____	_____
Arthritis ……..	_____	_____	_____	_____	_____	_____	_____	_____	_____
Osteoporosis ……	_____	_____	_____	_____	_____	_____	_____	_____	_____
Depression ……..		___	_____	_____	_____	_____	_____	_____	_____
Alzheimer's ……..			_____	_____	_____	_____	_____	_____	_____
Migraine…….			_____	_____	_____	_____	_____	_____	_____
Other_____			_____	_____	_____	_____	_____	_____	
								_____	

Please also complete the back of this form

Habits:

(please describe type, amount and year quit):

Tobacco _____

Alcohol _____

Caffeine (include sodas) _____

_____

IV drug use _____

Other _____

Occupational History:

(Type of work and nr. of years)

_____

_____

_____

_____

Environmental concerns (please circle):

fumes dust coal lead

noise asbestos radiation

mercury heavy lifting

other _____

_____

Immunizations (year):

Tetanus _____

Flu _____

Pneumovax _____

Hepatitis A _____

Hepatitis B _____

Other _____

Have you had recent (when):

Complete physical exam _____

Pap smear _____

Blood panel _____

ECG _____

Chest X-Ray _____

Mammogram _____

Dental exam _____

Eye exam _____

Colon screening _____

Bone Density Scan _____

Dietary habits: _____

Recent foreign travel: _____

_____

Exercise (please circle):

sedentary
(little exercise)

mild exercise
(climb stairs, walk over 3 blocks, golf, etc.)

occ. vigorous exercise
(work or recreation—less than 4x a week for 30 min)

reg. vigorous exercise
(work or recreation— 4x a week for 30 min.)

Circle any symptoms you have to a significant degree:

headache
fainting
dizziness
ear trouble
trouble hearing
sinus trouble
stuffy nose
allergy
hoarseness
trouble seeing
cough
wheezing
asthma
pleurisy
shortness of breath
night sweats
cough up blood
chest pain
heart trouble
heart murmur
rheumatic fever
enlarged heart
blood clots
seizures

irregular heartbeat
high blood pressure
ankle swelling
short of breath lying down
increased nighttime urination
leg pain with walking
varicose veins
indigestion
heart burn
stomach pain
ulcers
vomiting blood
gall bladder trouble
colitis
liver disease
blood in stool
black stools
diarrhea
constipation
change in bowels
hemorrhoids
anemia

blood disorder
diabetes
thyroid disease
kidney disease
urinary tract infections
difficulty urinating
frequent urination
pain with urination
blood in urine
urinary incontinence
impotence
infertility
other problems with sexual activity
hot flashes
nervousness
depression
difficulty sleeping
change in appetite
change in weight
difficulty concentrating
joint pain
back pain
muscle pain
numbness

other_____

Menstrual History:

age at first period _____

date of last period _____

frequency of periods _____

contraception __ _____

problems with periods _____

_____

_____

Pregnancies:

total _____

live births _____

miscarriages _____

terminations _____

complications

_____

_____

Other Health care providers and specialty: _____

_____

_____

_____