Rochester General Medical Groups
Adult Health History Form

Name		Date of Birth
Sex ☐ M ☐ F	Marital status ☐ S ☐ M ☐ D	Occupation
Education completed ☐ elementary ☐ high school ☐ college ☐ other		
Who do you live with?		
What are your major health concerns / reason for visit?		

Hospitalization/serious illness/injury	Date	Outcome
Update since last visit		

Family History *Update since last visit*

Relation	Age	State of health	Age of death	Cause of death
Father				
Mother				
Siblings				

Check (✓) if your blood relatives had any of the following	Disease	Relationship
	Anemia	
	Arthritis/gout	
	Asthma/ seasonal allergies	
	Cancer	
	Diabetes	
	Chemical dependency	
	Heart disease / stroke	
	High blood pressure	
	Kidney	
	Mental illness	
	Thyroid disease	
	Tuberculosis	
	Other	

Immunization history: When did you have the following?

Hepatitis	Gardasil	Rubella (MMR)
Influenza -seasonal	Pneumovax	Tetanus/diphtheria
Influenza – H1N1	PPD	Zoster

Do you have any barriers to learning? ☐ language ☐ sight ☐ hearing ☐ reading difficulties

How do you learn best? ☐ demonstration ☐ written ☐ audio / listening ☐ visual / observation

Health Habits:
(✓) all that apply

		yes / no / history of
	Caffeine	
	Recreational drugs	
	Alcohol history	daily / weekly
	Tobacco history	
	Special diet	
	Exercise	
	Seat belt	

Other:
Is pain a problem for you? ☐ yes ☐ no
If yes, please rate your pain on scale 0-10 _____
Are you currently feeling abused or threatened?
Verbal, sexual, or physical ☐ yes ☐ no
Sexual practice
☐ bisexual ☐ abstinent ☐ gay ☐ heterosexual
Number of sexual partners in last 5 years_____
Exposure to hazardous substances
☐ noise ☐ radiation ☐ chemicals ☐ paints
Do you have a Health Care Proxy? ☐ yes ☐ no
Birth control _____

When did you have the following?

Blood transfusion	Eye exam	Pap smear
Colonoscopy	Hearing test	Physical exam
Dental exam	Last menstrual period	
Dexascan	Mammogram	

List any abnormal results:

Allergic reaction to drug, food, insect, or injection?	
Substance	Reaction

Medications: list what you are currently taking. Include prescription, over the counter, vitamins, minerals and herbal supplements

Conditions you have or have had in the past (✓)

☐ abnormal EKG	☐ bowel polyp	☐ Emphysema	☐ Mental illness	☐ STD
☐ abnormal chest xray	☐ Bronchitis	☐ Gall bladder disease	☐ Measles	☐ Thyroid / Goiter
☐ AIDS/HIV	☐ Cancer	☐ Glaucoma	☐ Mononucleosis	☐ Tonsillitis
☐ Alcoholism	☐ Cataracts	☐ Gout	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Anemia	☐ Chemical dependency	☐ Heart murmur	☐ Pace Maker	☐ Typhoid fever
☐ Anorexia/Bulimia	☐ Colitis	☐ Herpes	☐ Pneumonia	☐ Stroke
☐ Arthritis	☐ Dentures	☐ High Blood Pressure	☐ Polio	☐ Ulcer
☐ Asthma/COPD	☐ Depression	☐ High Cholesterol	☐ Prostate problem	☐ Vaginal Infection
☐ Bladder problems	☐ Diabetes	☐ Kidney disease	☐ Rheumatic Fever	☐ Work injury
☐ Bleeding problem	☐ Diverticulitis	☐ Liver disease	☐ Seizure	☐ Other

Symptoms Check (✓) symptoms you have or have had in the past year

General	**Muscle/joint/bone**		☐ diarrhea	**Eye/Ears/Nose/Throat**	**Men only**
☐ chills	Pain/weakness/numbness		☐ excessive hunger/thirst	☐ bleeding gums	☐ breast lump
☐ depression	Paralysis/ swelling		☐ hemorrhoids	☐ difficulty swallowing	☐ erection difficulties
☐ dizziness	☐ Arms	☐ hips	☐ indigestion	☐ seasonal allergies	☐ lump in testicles
☐ fainting	☐ back	☐ legs	☐ nausea /vomiting	☐ loss of hearing	☐ penile discharge
☐ fever / sweats	☐ hands	☐ neck	☐ stomach pain	☐ sinus problem	**Women only**
☐ forgetfulness	☐ feet	☐ shoulders	**Cardiovascular**	☐ nose bleed	☐ hot flashes
☐ loss of balance	**Genito-urinary**		☐ Chest pain	☐ ringing in ears	☐ breast lump/pain
☐ loss of sleep	☐ bloody or cloudy urine		☐ high blood pressure	**vision**	☐ nipple discharge
☐ weight loss/gain	☐ frequent urination		☐ irregular heart beat	☐ blurred ☐ flashes	☐ vaginal discharge
☐ nervousness/stress	☐ loss of urine control		☐ low blood pressure	☐ double ☐ halos	☐ vaginal bleeding
Respiratory	☐ painful urination		☐ poor circulation	**Skin**	☐ problem pregnancies
☐ wheezing	**Gastrointestinal**		☐ rapid heart beat	☐ bruise easily	☐ menstrual problems
☐ short of breath	☐ poor appetite		☐ swelling ankles	☐ hives/itching/rash	☐ menopause
☐ coughing blood	☐ black or bloody stool		☐ varicose veins	☐ change in mole	**Other**
	☐ bowel changes			☐ non healing sore	
	☐ constipation				

I certify that the above information is correct.

Completed by _____ Date_____

Reviewed by _____ Date_____