DayOne
FAMILY HEALTHCARE

363 Fremont St., Suite 203
Battle Creek MI 49017
P: (269) 969-6123 F: (269) 969-6122
www.dayonehealthcare.com

ADULT HISTORY

Help Us Help You

This Health History is an important step in making quality health care available to you and your family. Please answer the questions below. This information will be kept confidential and used for your continuing care.

Please Print

Date: ____________________ Date of Last Physical Exam: ___________

Patients Name: ____________________________ Date Of Birth: ________________

Person completing this history: ____

Disease History

Please check any of the following you have or have had

Eye/Ear/Nose
__ Eye pain
__ Double Vision
__ Glaucoma
__ Hearing loss
__ Ringing of ears
__ None
__ Other __________

Heart
__ High Blood Pressure
__ Heart attack
__ Heart murmur
__ Chest Pain
__Shortness of breath
__Chest discomfort with exercise
__Heart disease
__None
__Other

Kidney/Bladder
__Urinate frequently
__Urinary pain or itching
__Urinary infection
__Leakage
__Kidney stones
__Bloody urine
__None
__Other ________

Lungs
__Bronchitis
__Emphysema
__ Sinusitis
__ Phlegm when coughing
__ Asthma
__Tuberculosis (TB)
__Chronic Cough
__ None
__ Other__________

Skin
__Acne
__Dermatitis
__Psoriasis
__Bruise easily
__None
__Other_________

Muscular/Skeletal
__Muscle weakness
__Back/Neck injury
__Backaches
__Broken Bones
__None
__Other _______

Nervous System
__Headaches
__Fainting or dizzy spells
__Epilepsy
__Head injury
__ Nerve injury
__None
__Other _______

Systemic
__Diabetes (sugar)
__Glandular trouble
__ Thyroid
__Unusual lumps
__Nipple discharge
__Stomach/bowel problem
__Hepatitis
__Yellow jaundice
__ Alcoholism
__ Night Sweats
__ AIDS
__ None
__Other ________

Teeth/Mouth
__Mouth sores
__Loose teeth
__Dentures
__None
__ Other _______

Vascular
__Circulation problem
__Anemia
__Sickle cell
__Bleeding tendencies (bleed easily)
__Nose Bleeds
__Calf pain
__ Ankle swelling

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ADULT HISTORY (continued)

List any surgeries/ operations (please include the year) ______________________________

____

List any allergic reactions or sensitivities to medication ______________________________

List any medications you are currently taking ______________________________

____

List your preferred pharmacy______________________________

Have you ever had any of the following illnesses:

__Chickenpox __Smallpox __German Measles __Hard Measles __Diphtheria

__Mumps __Scarlet Fever __Strep Throat

Do you have any of the following:

__Pacemaker __Defibrillator __Lead Wires __Metal in your Body

Women

Have you had any of the following problems:

___Breast lumps ___Discharge from nipples ___Vaginal discharge

___Uterine infection ___Bleeding between periods ___ Abnormal Pap Smears, if yes date? ______

___ Breast Cancer

Age of first period	_________	Number of living children	_________
Average number of days of flow	_________	Are you pregnant now?	_________
Length of time between periods	_________	Date of last pap smear	_________
Number of pregnancies	_________	Date of last mammogram	_________
Number of live births	_________	Have you ever had an abnormal pap smear?	_________
Number of miscarriages	_________	Have you ever had an abnormal mammogram?	______
Number of abortions	_________	Do you regularly perform self breast exams?	______

Men

Have you had any of the following problems:

__Frequent urination __Testicular pain or swelling __Prostate trouble __Impotence

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ADULT HISTORY (continued)

Do you regularly perform testicular exams? _______

Family History

Please check all that apply	Father	Mother	Father's parents	Mother's parents	Siblings Children
Heart Disease					
High Blood Pressure					
Stroke					
Cancer					
Glaucoma					
Diabetes					
Epilepsy					
Bleeding disorder					
Kidney disease					
Thyroid disease					
Mental illness					
Parkinson's disease					
Alzheimer disease					
Other					

Social History

Current smoker? _____
Cigars? _____
Cigarettes? _____
Packs per day? _____

Do you drink? _______
Liquor? _______
Beer? _______
How much? _______

Do you use illegal drugs? _____
What kind? _______
How often? _______

Former smoker? ______

Do you use chewing tobacco? ________________ How often? __________________

Have you ever been treated for alcohol or substance abuse? _________How long ago? ___________

Do you drink caffeinated beverages? ___________ How much? _________

How often do you exercise? _________________________

Yes or No

____Do you eat a low-fat diet?

____Do you eat a vegetarian diet?

____Do you wear seat belts?

____Do you have advanced directives/ DPOA in place?

____Do you wear a helmet while riding a bike or motorcycle?

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ADULT HISTORY (continued)

____If you have a gun in the home, is it out of children's reach?

____Do you have smoke detectors in your home?

____Do you have carbon monoxide detectors

____Is your home tobacco and smoke free?

____Have you served in the Military?

____Do you seek care at the VA?

____Do you travel for long periods of time?

____Do you feel safe in your home?

____Are you being abused?

What is your occupation? ______________________________

Have you ever been exposed to chemicals or radiation in the workplace? ______________________________

____

What is your highest level of education? ______________________________

If you are married, what is your spouse's occupation? ______________________________

Patient Signature: ______________________________ **Date:** ______________

Physician Signature: ______________________________ **Date:** ______________