ADVENTIST HEALTH
PORTLAND

Adult Health History

Patient Name: Sex: D.O.B.: Today's Date:

Please check all items that apply to you:

MEDICAL HISTORY

Blood / Heart / Circulatory:
- ☐ Anemia (what type: _____)
- ☐ Atrial Fibrillation
- ☐ Blood clots (where: _____)
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Heart Attack (when: _____)
- ☐ Heart murmur
- ☐ Hemophilia
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Valvular/Heart Disease Valve: _____
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Other: _____

Brain / Neurologic / Mental Health:
- ☐ ADD / ADHD
- ☐ Alcohol dependence
- ☐ Alzheimer's
- ☐ Anxiety
- ☐ Bi-Polar (manic depression)
- ☐ Depression
- ☐ Drug Dependence
- ☐ Eating disorder (Bulima, Anorexia)
- ☐ Headaches
- ☐ Meningitis
- ☐ Multiple Sclerosis
- ☐ Neuropathy _____
- ☐ Parkinson's
- ☐ Schizophrenia
- ☐ Seizures (type: _____)
- ☐ History of Head Injury
- ☐ Other: _____

Endocrine:
- ☐ Diabetes: Juvenile-onset (Type I); Adult-onset (Type II)
- ☐ Polycystic Ovaries
- ☐ Testicular hypofunction
- ☐ Thyroid: Hypothyroidism; Hyperthyroidism; Goiter
- ☐ Other: _____

Kidney / Urinary / Prostate:
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Kidney disease / stones (type: _____)
- ☐ Kidney Infection
- ☐ Prostate enlargement
- ☐ Prostatitis
- ☐ Urinary tract infection, recurrent
- ☐ Other: _____

Respiratory / Lung:
- ☐ Asthma
- ☐ Bronchitis, chronic
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Emphysema
- ☐ Hay fever
- ☐ Pneumonia, hospitalized? ☐ Yes ☐ No
- ☐ Sleep apnea
- ☐ Smoking history _____
- ☐ Other: _____

Gastrointestinal:
- ☐ Cirrhosis
- ☐ Colon polyps
- ☐ Crohn's disease
- ☐ History of Diverticulitis
- ☐ Esophagitis
- ☐ GERD / Heartburn
- ☐ Gallbladder problems
- ☐ GI bleed or ulcer
- ☐ History of Hepatitis / Jaundice
- ☐ Hernia (what type: _____)
- ☐ Umbilical Ventral Hiatal Inguinal (R /L)
- ☐ Irritable bowel
- ☐ Pancreatitis
- ☐ Other: _____

Ophthalmology:
- ☐ Amblyopia (crossed eye)
- ☐ Astigmatism
- ☐ Blindness
- ☐ Cataract: _____ right eye _____ left eye
- ☐ Color blindness
- ☐ Diabetic retinopathy
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Optic Neuritis
- ☐ Retinal detachment
- ☐ Retinal Hemorrhage
- ☐ Strabismus (lazy eye)
- ☐ Other: _____

Ear / Nose / Throat:
- ☐ Allergies:
- ☐ Benign positional vertigo (dizziness)
- ☐ Bloody nose frequently
- ☐ Chronic rhinitis (runny nose)
- ☐ Chronic sinusitis
- ☐ Chronic Ear infections, _____ right ear _____ left ear
- ☐ Hearing loss
- ☐ Meniere's disease
- ☐ Nasal polyps
- ☐ Other: _____

MEDICAL HISTORY (Continued)

Cancer
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Injuries / Fractures:
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Rheumatology / Orthopedic:
- ☐ Gout
- ☐ Osteoarthritis, where: _____
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis, where: _____
- ☐ Sciatica
- ☐ Fracture History: _____
- ☐ Other: _____

Infectious disease:
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ HIV
- ☐ Tuberculosis
- ☐ Places traveled: _____
- ☐ Other: _____

Dermatology
- ☐ Acne
- ☐ Atopic dermatitis (eczema)
- ☐ Boils
- ☐ Contact dermatitis
- ☐ Fungal infections: _____
- ☐ Hirsutism (excessive hair growth)
- ☐ Psoriasis
- ☐ Urticaria (hives)
- ☐ Other: _____

Reproductive Health
- ☐ Are you sexually active? _____ yes _____ no
- ☐ Form of birth control: _____

(for men):
- ☐ Impotence
- ☐ Other: _____

(for women):
- ☐ Last menstrual period: _____
- ☐ Abnormal Pap smear: _____
- ☐ Endometriosis
- ☐ Gestational Diabetes
- ☐ Menopause (age: _____)
- ☐ Ovarian Cyst
- ☐ Post-menopausal bleeding
- ☐ Pregnancies: Total # of pregnancies: _____
- ☐ Live births #_____ Vag. Del or C Section Miscarriage # _____
- ☐ Abortion #_____ Ectopic pregnancy # _____, D&C _____
- ☐ Other: _____

SURGICAL HISTORY

	Date
☐ Abdominal: _____	_____
☐ Appendix: ☐Open ☐Laparoscopy	_____
☐ Back, what: _____	_____
☐ Bone / Joint: (where: _____)	_____
☐ Breast: ☐right ☐left; _____	_____
reconstruction? _____ ☐ Implant ☐ Reduction	
☐ Cataract: ☐ right ☐ left; lens replaced?	_____
☐ Gallbladder: ☐ Open ☐ Laproscopy	_____
☐ Heart (what type: _____)	_____
☐ Hemorrhoidectomy	
☐ Hernia (what kind, where: _____)	_____
☐ Hysterectomy: Vaginal or Abdominal; _____	_____
reason: _____	
Do you still have ovaries? ☐Yes ☐No	

	Date
☐ Lung: ☐right ☐left; why? _____	_____
☐ Pacemaker inserted	_____
☐ Prostate removal / TURP (resection of prostate)	_____
☐ Rhinoplasty _____	_____
☐ Splenectomy	_____
☐ Tonsils (w / adenoids? _____) age: _____	_____
☐ Thyroid _____	_____
☐ Transplant, what: _____	_____
☐ Tubal ligation: ☐ Open ☐ Laproscopy	_____
☐ Vasectomy	_____
☐ Fracture Repair: _____	_____
☐ Other: _____	_____
☐ Other: _____	_____
☐ Other: _____	_____
☐ Other: _____	_____

FAMILY HISTORY

☐ **Adopted**

Relationship to you (please note multiple siblings / children of same sex):

	Mom	Dad	Sister	Brother	Mother's mother	Mother's father	Father's mother	Father's father	Daughter	Son	Other: Specify who
Alcohol / Drugs											
Anesthesia Reaction											
Arthritis											
Auto-immune											
Blood Disease											
Cancer (specify)											
Dermatology											
Diabetes (Type I or II)											
EENT											
Endocrine											
Gastro-intestinal											
Genitourinary											
Heart / vascular											
High blood pressure											
High Cholesterol											
Lung											
Musculoskeletal											
Neurologic condition											
Psychiatry											
Renal disease											
Stroke											
Thyroid disease											
Other											
Family Status											
Living											
Deceased											
Age at death											
Cause of death											
Unknown											

SOCIAL / PERSONAL HISTORY

Alcohol consumption: ☐ Yes ☐ No (type _____
amount _____ frequency_____)

Have you ever used street drugs? ☐ Yes ☐ No
(type: _____
treatment: _____)

Smoker: ☐ Yes ☐ No ☐ Former
Age Started:_____ Packs per day:_____
Age Quit: _____
☐ Smokeless Tobacco/Chew
☐ Cigar ☐ Pipe ☐ E-cig ☐ Vape

Occupation: _____

Marital Status:_____

Spouse's Name: _____

Number of Children: _____

Years of Education: _____
☐ Finished High School
☐ Technical Degree
☐ College Degree
☐ Post Graduate Degree

Advanced Care Planning
☐ POLST:_____
☐ Advance Directive: _____
☐ Power of Attorney: _____
☐ Guardian: _____
☐ Healthcare Directive: _____
☐ Other: _____

Preventative Care Planning
Please list the location where you last completed any of the following tests:

	Location	*Date*
☐ Colonoscopy		
☐ DEXA Bone scan		
☐ Mammogram		
☐ Pap smear		

ADULT QUESTIONNAIRE

1. During the past month have you often been bothered by feeling down, depressed or hopeless?
_____ Yes _____ No

2. During the past month have you often been bothered by little interest or pleasure in doing things?
_____ Yes _____ No

3. Have you ever been hit, kicked, punched, or otherwise hurt by someone in the past year?
_____ Yes _____ No

4. Do you feel safe in your current relationship?
_____ Yes _____ No

5. Is there a partner from a previous relationship who is making you feel unsafe now?
_____ Yes _____ No

6. How many times in the past year have you used a recreational drug or used a prescription drug for non-medical reasons?_____

7. How often do you have four (4) or more alcoholic drinks on one occasion? Never Monthly Weekly Daily