

TRIANGLE COMMUNITY PHYSICIANS, P.A.  
ADULT HEALTH HISTORY FORM

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of last Physical: \_\_\_\_\_

Reason for visit/health issues to discuss:

1. \_\_\_\_\_ 3. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_

MEDICAL HISTORY		SURGICAL HISTORY	
Year	Medical problems/Illness/Hospitalization <input type="checkbox"/> None	Year	Prior Surgeries/Operations <input type="checkbox"/> None

CURRENT MEDICATIONS including over-the-counter medicines, herbs, vitamins, birth control pills	ALLERGIES medications/foods
<input type="checkbox"/> None	<input type="checkbox"/> None

CHILDHOOD ILLNESSES	
Chicken pox <input type="checkbox"/> had disease <input type="checkbox"/> Never <input type="checkbox"/> Received vaccine	Mumps <input type="checkbox"/> Received vaccine <input type="checkbox"/> had disease <input type="checkbox"/> Never
Measles <input type="checkbox"/> Received vaccine <input type="checkbox"/> Never <input type="checkbox"/> had disease	Rheumatic fever <input type="checkbox"/> Never <input type="checkbox"/> had disease

VACCINATIONS	
Tetanus vaccine:    Date: <input type="checkbox"/> Under 10 years ago <input type="checkbox"/> Over 10 years ago	
Hepatitis B vaccine <input type="checkbox"/> Not received <input type="checkbox"/> Completed series (3 shots)	
HPV vaccine (cervical cancer): <input type="checkbox"/> Not received <input type="checkbox"/> Completed series (3 shots)	
Pneumonia vaccine    Date: <input type="checkbox"/> Not received	
Zostavax (shingles vaccine) Date: <input type="checkbox"/> Not received	

**PLEASE COMPLETE BACK SIDE OF FORM ➔**

### HEALTH MAINTENANCE

Stress Test	Date:	<input type="checkbox"/> Never	Mammogram	Date:	<input type="checkbox"/> Never
Colonoscopy	Date:	<input type="checkbox"/> Never	Bone Density testing	Date:	<input type="checkbox"/> Never

### WOMEN'S HEALTH (if applicable)

<b>Pregnancies</b>		<b>Birth control:</b> <input type="checkbox"/> none <input type="checkbox"/> pills <input type="checkbox"/> patch <input type="checkbox"/> IUD <input type="checkbox"/> tubal ligation <input type="checkbox"/> vasectomy <input type="checkbox"/> withdrawal <input type="checkbox"/> Condoms <input type="checkbox"/> trying to get pregnant	<b>Pregnancy complications:</b> <input type="checkbox"/> None <input type="checkbox"/> Diabetes <input type="checkbox"/> Blood pressure <input type="checkbox"/> Other _____
Total number pregnancies		<b>Menstrual periods:</b> Last period: _____ Age at 1 <sup>st</sup> period: _____ Age at menopause _____	<b>Pap smears:</b> Date: _____ Abnormals? Have you ever had any STD's? <input type="checkbox"/> No <input type="checkbox"/> Yes Specify:
Full term infants			
Premature infants			
Abortions/Miscarriages			
Living children			

### SOCIAL HISTORY

<b>Marital status:</b> <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed	<b>Caffeine:</b> Type, Amount and how often: <input type="checkbox"/> None
<b>Occupation:</b>	<b>Exercise:</b> Type and how often: <input type="checkbox"/> None
<b>Education: highest level completed:</b> <input type="checkbox"/> Middle school <input type="checkbox"/> GED <input type="checkbox"/> High school grad <input type="checkbox"/> 2yr college/technical school <input type="checkbox"/> BS/BA College graduate <input type="checkbox"/> Graduate School <input type="checkbox"/> PhD/professional school	<b>Diet:</b> <input type="checkbox"/> No specific <input type="checkbox"/> Diabetic <input type="checkbox"/> Vegetarian <input type="checkbox"/> Low fat/low cholesterol
<b>Type Sex partners:</b> <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both Number of sex partners: Lifetime: Last 6 mo:	<b>Illicit drugs:</b> <input type="checkbox"/> never <input type="checkbox"/> current <input type="checkbox"/> quit <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> IV drugs
<b>Tobacco:</b> <input type="checkbox"/> never <input type="checkbox"/> current <input type="checkbox"/> quit Average amount: How long?:	<b>Pets in home:</b> <input type="checkbox"/> cat(s) <input type="checkbox"/> dog(s)
<b>Alcohol:</b> <input type="checkbox"/> Never <input type="checkbox"/> occasional <input type="checkbox"/> regular <input type="checkbox"/> former alcoholic Average amount:	<b>Living Will:</b> <input type="checkbox"/> Do not have one <input type="checkbox"/> have one <input type="checkbox"/> would like to discuss Current status: <input type="checkbox"/> full code <input type="checkbox"/> Limit futile treatment <input type="checkbox"/> DNR

### FAMILY HISTORY

	Age/Age of death	Illnesses	Cause of death
Father	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Mother	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Brothers	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Sisters	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Children	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		