

Patient History Form: Adult (18 & over)-Brief

Please fill out this form completely to provide your physician with information

Name _____

Occupation _____

Marital Status _____

Spouses Name _____

Spouses Occupation _____

Number of children in the home _____

1. Do you see any specialists? If yes, list name and specialty.

2. What problems/concerns do you have regarding your health?

3. Please circle the following answers.

Do you....

Smoke/ chew tobacco	Y	N	Quit (date)_____
Drink caffeine (cof/pop/tea)	Y	N	Amt _____
Drink alcohol	Y	N	Amt _____
Wear seatbelts	Y	N	Sometimes
Wear sunscreen	Y	N	Sometimes
Exercise	Y	N	Amt _____
Eat Fruit & Vegetables	Y	N	Amt _____
Need help dressing	Y	N	Sometimes
Use a cane or walker	Y	N	Sometimes
Keep track of your own medicines	Y	N	
Drive a car?	Y	N	

4. Please **CIRCLE** any problems you have in the last **WEEK.**

Fevers	Urinary Incontinence
Night Sweats	Problems in Urine Flow
	Vaginal Bleeding
Weight Changes	Skin Growths
Blurred Vision	Falling
Trouble Hearing	Headaches
Chest Pain/Discomfort	Fainting
Swelling in Feet	Forgetfulness
Cough	Confusion
Difficulty Breathing	Others worried about your memory
Abdominal Pain	Depression
Decreased Appetite	Mood Swings
Difficulty Swallowing	Thought of Suicide
Constipation	Hopeless Feelings
Blood in stool	Loss of interest in things
Vomiting	
Change in Stools	