BELLINGHAM
NATURAL FAMILY MEDICINE

ADULT HEALTH HISTORY

To help us meet your healthcare needs, please fill out this form completely in ink. This is a confidential record of your health history.

Today's date: _____
Name: (Last, First, M.I.): _____ Date of birth _____ Age ____
Do you have children? _____ If so, please list names and ages: _____
Relationship status: S, M, S/D,W Spouse/domestic partner's name: _____
Your profession: _____ How many hrs/wk do you work? _____
What are your goals for the visit today? Please be specific. _____
_____
_____
Are there any specific conditions that you are concerned about? _____
_____
Date of last physical exam _____ Name of primary care doctor _____
Date of last dental exam _____, Eye exam _____, Mammogram _____,
Colonoscopy _____, Blood test _____, Bone density testing _____
Names of your other healthcare providers: _____
_____
Food allergies/intolerances and reaction(s) they cause: _____
_____
Drug allergies/reactions: _____
Environmental allergies: _____
Serious illnesses, surgeries, and other hospitalizations you have had and dates they occurred: __
_____
_____
Serious accidents, severe injuries, broken bones and dates: _____
_____
Please list all prescription and over-the-counter medications you are currently taking including dosages:
_____
_____
Please list all nutritional and herbal supplements you are taking including brand names and dosages:
_____
_____
Current weight: _____ Happy with weight? _____ Weight at high school graduation: _____
Daily exercise: Light—Medium—Heavy What is your current exercise routine (type of exercise, # of minutes/day, # days/wk): _____
_____Do you enjoy it? _____
How much sleep do you get each night? _____ From: _____p.m. to: _____a.m.
How well do you sleep? _____
Over the past few years, how would you describe your stress level? Mild—Moderate—Severe
In the past several months, can you say that you:
Enjoy your job/what you do during the day? _____
Enjoy your relationship with people in your life? _____
Are you feeling confident about your ability to cope? _____

Diet: Are you vegetarian – vegan – avoiding allergens? _____
Please list foods you typically eat:

Breakfast: _____
Snack: _____
Lunch: _____
Snack: _____
Dinner: _____
Snack: _____
Dessert: _____

How much of each of the following beverages do you typically drink per day/week/month/year?
Water: _____, Soda: _____, Coffee (decaf or regular): _____, black tea: _____, green tea: _____, fruit juice: _____, beer/wine/other alcohol: _____, Other: _____

Lifestyle: Smoking (amount per day): _____ If former smoker, date quit: _____
Recreational drugs (type & amount per week) _____
Do you always wear a seat belt while in a vehicle? _____ Do you practice safe sex practices? _____
Do you always wear a helmet while on a bike or motorcycle? _____
Have you ever felt threatened by an intimate partner or ex-partner? _____
Do you know of any exposure, past or present, to any of the following: mercury – lead – arsenic – herbicides – pesticides– other toxic chemicals? _____

Review of systems: Check any of the following symptoms that you have experienced in the past 3 months and record how frequently you have had them:

_____ Heartburn
_____ Abdominal bloating
_____ Abdominal discomfort/pain
_____ Diarrhea
_____ Constipation
_____ Vomitting
_____ Nausea
_____ Decrease/increase in appetite
_____ Rectal bleeding
_____ Black, tarry stools
_____ Persistent fever
_____ Weight loss/gain
_____ Increase in thirst
_____ Muscle weakness or paralysis
_____ Joint pain or stiffness
_____ Swollen joints
_____ Muscle cramps or spasms
_____ Leg cramps walking/at night
_____ Easy bleeding/bruising
_____ Frequent nosebleeds
_____ Varicose veins
_____ Hemorrhoids
_____ Migraines
_____ Other headaches

_____ Dark urine
_____ Frequent urination in day
_____ Frequent urination in night
_____ Painful urination
_____ Leakage of urine
_____ Blood in urine
_____ Difficulty starting urine
_____ Eye pain
_____ Double/blurred vision
_____ Discharge from eyes
_____ Breast lump/discharge
_____ Heart palpitations/fluttering
_____ Chest pn/ discomfort
_____ Shortness of breath
_____ Wheezing
_____ Bloody sputum
_____ Persistent hoarseness
_____ Chronic/frequent cough
_____ Frequent colds
_____ Sore throat
_____ Cold sores
_____ Cankersores
_____ Night sweats
_____ Hot flashes--daytime

_____ Tire easily/weakness
_____ Depression
_____ Memory loss
_____ Lack of sex drive
_____ Dizziness/fainting
_____ Sleeplessness
_____ Poor coordination
_____ Changes in nails/hair
_____ Abnormal hairloss
_____ Sensitivity: heat/cold
_____ Dry skin
_____ Rash
_____ Acne
_____ Rosacea
_____ Eczema
_____ Other skin changes

Men only:
_____ Discharge from penis
_____ Impotence
_____ Pain/lump in testicles

Women only:
Age period began: _____, If menstruating, how long on your monthly cycles? _____,
Date of last menstrual cycle: _____, Date of last pelvic exam: _____,
Are you sexually active? _____, If so, what form of birth control do you use: BCPs, condoms, diaphragm, natural family planning, other: _____
During your heaviest bleeding, menstrual pads/tampons are changed every _____ hour(s)

_____ Heavy menstrual bleeding
_____ Spotting between periods
_____ Painful menstrual cramping
_____ History of abnormal paps/HPV+
_____ Painful intercourse
_____ Vaginal or vulvar itching

Past Medical History: (Please check space for conditions you have had in the past)

_____ Measles
_____ Mumps
_____ Chickenpox
_____ Whooping cough
_____ Scarlet Fever
_____ Pneumonia
_____ Rheumatic fever
_____ Strep throat
_____ Sinus infection(s)
_____ Ear infection(s)
_____ Chronic diarrhea
_____ Chronic constipation
_____ Chronic abdominal pain
_____ Venereal Disease
_____ Gallbladder disease/stones
_____ Bladder infection(s)
_____ Epilepsy
_____ Bleeding tendancy
_____ Migraine headaches
_____ Tuberculosis
_____ Diabetes
_____ Cancer
_____ Polio
_____ Seasonal allergies
_____ Hernia
_____ Blood/plasma transfusion
_____ Back problems
_____ High blood pressure
_____ Heart disease
_____ Hives
_____ Eczema
_____ AIDS/HIV+
_____ Irregular menstrual cycles/bleeding
_____ ADD/ADHD
_____ Chronic or frequent bronchitis
_____ Mitral valve prolapse
_____ Stroke
_____ Ulcer
_____ Heartburn
_____ Arthritis
_____ Kidney stones
_____ Kidney disease
_____ Hypothyroid
_____ Hyperthyroid
_____ Asthma
_____ Anemia
_____ Osteoporosis
_____ PMS
_____ Depression
_____ Anxiety disorder
_____ Hepatitis
Other: (please list)
_____
_____

Family Medical History:
Please fill in any health conditions for the following biological relatives. If they are deceased, please include age and cause of death.
Mother: _____
Maternal Grandmother: _____
Maternal Grandfather: _____
Maternal Aunts/Uncles: _____
Father: _____
Paternal Grandmother: _____
Paternal Grandfather: _____
Paternal Aunts/Uncles: _____
Sister/brother: _____

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my health status. I also authorize the healthcare staff to perform the necessary health care services I may need.

_____ _____
Signature of patient Date