Salmon Falls
family healthcare

www.SalmonFallsMD.com

Adult Health History Form

Name:_____ **Date Of Birth:**_____/_____/_____

Who was your previous primary care provider? _____

Reason for today's visit:_____

CURRENT MEDICATIONS

Name of Medication	**Strength** (ex. 500 mg)	**Dosing Instructions** (ex. Twice a day)

ALLERGY HISTORY

☐ No Known Allergies ☐ Medication Allergies ☐ Environmental/Seasonal Allergies ☐ Latex Allergies

Allergen (ex. Food, Dust, Animals, Pollen, Medication)	**Reaction** (ex. Rash, nausea, respiratory, shock, etc.)

MEDICAL HISTORY (Please check any of the following that you have or have had in the past)

☐ Acid Reflux/GERD
☐ ADHD
☐ Alcoholism
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Bowel Problems
☐ Cancer
☐ Chronic Cough
☐ Chronic Pain
☐ COPD/Emphysema
☐ Dementia
☐ Depression
☐ Diabetes
☐ Eating Disorder
☐ Glaucoma/Cataracts
☐ Headaches
☐ Hearing Loss
☐ Heart Disease
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV/AIDS
☐ Kidney Disease
☐ Immune Disorders
☐ Liver Disease
☐ Osteoporosis
☐ Seizure Disorder
☐ Sexually Transmitted Disease
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Other: _____

SURGICAL HISTORY (Please list all past surgeries/operations):

Type of Operation	**Date**	**Type of Operation**	**Date**

MEDICAL AND MENTAL HEALTH HISTORY (Include all injuries or hospitalizations)**:**

Name of Facility	Reason	Date

FAMILY HISTORY *(Please tell us about the health of your immediate family)*

	Father	Mother	Siblings	Children	Other
Age at Death					
Cause of Death					
Heart Disease/ Stroke					
High Blood Pressure					
Diabetes					
Cancer (type)					
Epilepsy					
Asthma					
Blood Disease					
Other:					

SOCIAL HISTORY *(Please circle all applicable responses)*

Marital Status	Single Significant Other Married Divorced Widowed	
Living Situation	Alone Spouse/Significant other Children/Family Other	
Females- Are you pregnant?	Yes / No Hysterectomy Menopause Tubal ligation	
Do you have children?	Yes / No	If yes, how many?
Do you have animals?	Yes/ No	If yes, how many?
Education (highest level)	9 10 11 12 Some college Associates Bachelors GED Masters PhD	
Are you working?	Yes / No	If yes, occupation?
Are you disabled?	Yes / No	If yes, reason?

			If applicable, amount?
Tobacco Use? *If no, have you ever?*	Yes / No Yes / No	Cigarettes / Cigars / Chew Cigarettes / Cigars / Chew	Per day: Per day:
Exposed to second hand smoke?	Yes / No		
Do you drink alcohol?	Yes / No	Beer / Wine / Liquor	Per day:
Do you drink caffeine?	Yes / No	Coffee / Tea / Soda / Energy Drink	Per day:
Any present illicit drug use?	Yes / No	Marijuana / Cocaine / Heroin / Illicit Rx. / Other	
Any past illicit drug use?	Yes / No	Marijuana / Cocaine / Heroin / Illicit Rx. / Other	
Do you exercise?	Yes / No	Type?	Per week:
Do you wear your seatbelt?	Yes / No	If yes, percent of time:	
Do you have Advanced Directives in place?	Yes / No	Living Will Durable Power of Attorney Health Care Proxy Advanced Directives	

PREVENTATIVE CARE HISTORY

Please provide the dates and results of the following immunizations, examinations, and test to the best of your ability. If you have not had one of these services please indicate N/A (not applicable).

Last Tetanus Booster	☐ Within past 10 years	☐ More than 10 years ago		☐ N/A
Last Eye Examination	Date:_____	☐ Normal	☐ Abnormal	☐ Unknown
Last Hearing Exam	Date:_____	☐ Normal	☐ Abnormal	☐ Unknown
Last Colonoscopy or stool test	Date:_____	☐ Normal	☐ Abnormal	☐ Unknown
Last Bone Density Scan	Date:_____	☐ Normal	☐ Abnormal	☐ Unknown
Last Pneumonia Vaccine	Date:_____	☐ Normal	☐ Abnormal	☐ Unknown
Flu shot this season?	☐ Yes ☐ No			
Women:				
Last Pap Smear	Date:_____	☐ Normal	☐ Abnormal	☐ Unknown
Last Mammogram	Date:_____	☐ Normal	☐ Abnormal	☐ Unknown
Men:				
Last Prostate Specific Antigen	Date:_____	☐ Normal	☐ Abnormal	☐ Unknown
Last Prostate Exam	Date:_____	☐ Normal	☐ Abnormal	☐ Unknown

The above information is thorough and accurate to the best of my knowledge.

_____ _____

Patient Signature (or Guardian) **Date**