Carriage House Medicine
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Adult Health History

SUCCESSFUL HEALTH CARE AND PREVENTATIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PHYSICIAN HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

Name:_____ Birthdate:_____

Are you currently receiving healthcare? ☐ Yes ☐ No

If yes, where and from whom?

What is the reason for this visit?

What are your most important health problems? List in the order of importance.

- 1._____
- 2. _____
- 3. _____
- 4. _____

- 5. _____
- 6. _____

Do you have any known contagious diseases at this time? Y N

If yes, what?

Do you have a religious/spiritual practice and how important is it in your life?

FAMILY HISTORY

	FATHER	MOTHER	BROTHER	SISTER	SPOUSE	CHILD
Age (if living)						
Health G=good P=poor						
Age at death (if deceased)						
Cancer						
Diabetes						
Heart disease						
High blood pressure						
Stroke						
Epilepsy						
Mental illness						

Asthma/hayfever/hives

Anemia

Kidney disease

Glaucoma

Tuberculosis

Cause of death

Y= condition you have now N=never had P= a condition you have had in the past

CHILDHOOD ILLNESSES:

(please circle if you had the condition)

Scarlet fever Mumps Rheumatic fever German measles Lyme disease

Diptheria Measles Whooping Cough Chicken pox

HOSPITALIZATIONS:

What hospitalizations or surgeries have you had? _____year:

_____ year:_____ year:

X-RAYS AND SPECIAL STUDIES

Name any x-rays, CAT scans, MRI's or other special studies you have had:

Electrocardiogram: Y N Electroencephalogram: Y N

IMMUNIZATIONS:

List any additional as well

MMR	DtAP	Polio	Tetanus booster
Hepatitis B	HIB	Chicken pox	Flu shot

DAILY HABITS:

Drink alcohol	Eat sugar	Caffeine	Smoke:
			How long?
Amount per week:		Amount:	
			How many per day?

Exercise:	Sleep:	Chemical exposure:	Relaxation:
How often?	How much?	Pesticides	Your methods:
		Solvents	
What type?		Metals	
		Other	

Do you eat 3 meals a day?

DIET:

Please describe a typical day including snacks

Breakfast:

Lunch:

Dinner:

Drinks:

Snacks:

Allergies (to drugs, foods, environmentals):

CURRENT MEDICATIONS:

Laxatives	Pain relievers	Antacids
Cortisone	Appetite suppressants	Antibiotics
Tranquilizers	Thyroid medication	Sleeping pills

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking?

What do you enjoy most in your life?

How much change are you willing to make at this time for your health?

Minimal Some Complete

Is there any additional information about your health you would like to add?

REVIEW OF SYSTEMS:

Y= a condition you have now N= never had P= a condition you have had before

MENTAL/EMOTIONAL

Treated for emotional problems	Y P N	Depression	Y P N
Mood swings	Y P N	Anxiety or nervousness	Y P N
Considered/attempted suicide	Y P N	Tension	Y P N
Poor concentration	Y P N	Memory Problems	Y P N

ENDOCRINE

Hypothyroid	Y P N	Heat or cold intolerance	Y P N
Hypoglycemia	Y P N	Diabetes	Y P N
Excessive thirst	Y P N	Excessive hunger	Y P N
Fatigue	Y P N	Seasonal depression	Y P N

IMMUNE

Vaccinations	Y P N	Reactions to vaccinations	Y P N
Chronic Fatigue Syndrome	Y P N	Chronic infections	Y P N
Chronically swollen glands	Y P N	Slow wound healing	Y P N

NEUROLOGIC

Seizures	Y P N	Paralysis	Y P N
Muscle weakness	Y P N	Numbness or tingling	Y P N
Loss of memory	Y P N	Easily stressed	Y P N
Vertigo or dizziness	Y P N	Loss of balance	Y P N

SKIN

Rashes	Y P N	Eczema, hives	Y P N
Acne, boils	Y P N	Itching	Y P N
Color change	Y P N	Perpetual hair loss	Y P N
Lumps	Y P N	Night sweats	Y P N

HEAD

Headaches	Y P N	Head injury	Y P N
Migraines	Y P N	Jaw/TMJ problems	Y P N

EYES

Spots in eyes	Y P N	Cataracts	Y P N
Impaired vision	Y P N	Glasses or contacts	Y P N
Blurriness	Y P N	Eye pain/strain	Y P N
Color blindness	Y P N	Tearing or dryness	Y P N
Double vision	Y P N	Glaucoma	Y P N

EARS

Impaired hearing	Y P N	Ringing	Y P N
Earaches	Y P N	Dizziness	Y P N

NOSE & SINUSES

Frequent colds	Y P N	Nose bleeds	Y P N
Stuffiness	Y P N	Hay fever	Y P N
Sinus problems	Y P N	Loss of smell	Y P N

MOUTH & THROAT

Frequent sore throat	Y P N	Copious saliva	Y P N
Teeth grinding	Y P N	Sore tongue/lips	Y P N
Gum problems	Y P N	Hoarseness	Y P N
Dental cavities	Y P N	Jaw clicks	Y P N

NECK

Lumps	Y P N	Swollen glands	Y P N
Goiter	Y P N	Pain or stiffness	Y P N
	RESPIRATORY		
Cough	Y P N	Sputum	Y P N
Spitting up blood	Y P N	Wheezing	Y P N
Asthma	Y P N	Bronchitis	Y P N
Pneumonia	Y P N	Pleurisy	Y P N
Emphysema	Y P N	Difficulty breathing	Y P N
Shortness of breath at night	Y P N	Shortness of breath lying down	Y P N
Tuberculosis	Y P N		
	CARIOVASCULAR		
Heart disease	Y P N	Angina	Y P N
High/low blood pressure	Y P N	Murmurs	Y P N
Blood clots	Y P N	Fainting	Y P N
Rheumatic fever	Y P N	Chest pain	Y P N
Swelling in ankles	Y P N		
	GASTROINTESTINAL		
Trouble swallowing	Y P N	Heartburn	Y P N
Change in thirst	Y P N	Change in appetite	Y P N
Nausea	Y P N	Vomiting	Y P N
Vomiting blood	Y P N	Bowel movements, how often	
Blood in stool	Y P N	Is this a change?	
Pain or cramps	Y P N	Constipation	Y P N
Belching or passing gas	Y P N	Diarrhea	Y P N

Black stools	Y P N	Gall bladder	Y P N
Jaundice (yellow skin)	Y P N	Ulcer	Y P N
Liver disease	Y P N	Hemorrhoids	Y P N

URINARY

Pain on urination	Y P N	Increased frequency	Y P N
Frequency at night	Y P N	Inability to hold urine	Y P N
Frequent infections	Y P N	Kidney stones	Y P N

MALE REPRODUCTION

Hernias	Y P N	Testicular masses	Y P N
Testicular pain	Y P N	Prostate disease	Y P N
Venereal disease	Y P N	Discharge or sores	Y P N
Are you sexually active	Y N	Chlamydia	Y P N
Sexual orientation:		Gonorrhea	Y P N
Impotence	Y P N	Condyloma	Y P N
Premature ejaculation	Y P N	Herpes	Y P N
Birth control? Type:	Y N	Syphilis	Y P N

FEMALE REPRODUCTION

Age of first menses:_____		Are cycles regular?	Y N
Age of last menses:_____		Bleeding between cycles	Y P N
Length of cycle:_____days		Pain during intercourse	Y P N
Duration of menses:_____days	Y P N	Sexual difficulties	Y P N
Painful mensus	Y P N	Sexual orientation:_____	
Heavy of excessive flow	Y P N	Clotting	Y P N

PMS? What are the symptoms?	Y P N	Discharge	Y P N
		Birth control? Type:	Y N
		Are you sexually active?	Y N
Endometriosis	Y P N	Number of pregnancies?_____	
Ovarian cysts	Y P N	Number of live births:_____	
Difficulty conceiving	Y P N	Number of miscarriages:_____	
Cervical dysplasia	Y P N	Number of abortions:_____	
Abnormal PAP	Y P N	Menopausal syptoms	Y P N
Venereal disease	Y P N	Do you do breast self-exams?	Y P N
Chlamydia	Y P N	Breast pain/tenderness	Y P N
Gonorrhea	Y P N	Breast lumps	Y P N
Condyloma	Y P N	Nipple discharge	Y P N
Herpes	Y P N		
Syphilis	Y P N		

MUSCULOSKELETAL

Joint pain or stiffness	Y P N	Arthritis	Y P N
Broken bones	Y P N	Weakness	Y P N
Muscle spasms or cramps	Y P N	Sciatica	Y P N

BLOOD/PERIPEHERAL VASCULAR

Easy bleeding or bruising	Y P N	Anemia	Y P N
Deep leg pain	Y P N	Cold hands/feet	Y P N
Varicose veins	Y P N	Thrombophlebitis	Y P N

Welcome! We are glad to serve you! If you have questions, please call.