Patient: ALLERGIES:

Adult Ambulatory Patient History

General Information

Chief Complaint *(Reason for today's visit)*	

Health History I

Cardiovascular System History	Self	Family	None	Comments
Chest Pain/Angina Medical History	⬭	⬭	⬭	
Heart Attack Medical History	⬭	⬭	⬭	
High Blood Pressure Medical History	⬭	⬭	⬭	

Respiratory System History	Self	Family	None	Comments
Asthma Medical History	⬭	⬭	⬭	
Emphysema Medical History	⬭	⬭	⬭	
Sleep Apnea Medical History	⬭	⬭	⬭	

Gastrointestinal System History	Self	Family	None	Comments
Hepatitis Medical History	⬭	⬭	⬭	
Reflux Disease Medical History	⬭	⬭	⬭	

Health History II

Endocrine/Metabolic History	Self	Family	None	Comments
Diabetes Medical History	⬭	⬭	⬭	
Thyroid Disease History	⬭	⬭	⬭	

Neurological System History	Self	Family	None	Comments
Numbness/Tingling Medical History	⬭	⬭	⬭	
Stroke Medical History	⬭	⬭	⬭	

Psychiatric History	Self	Family	None	Comments
Addictions Medical History	⬭	⬭	⬭	
Anxiety Medical History	⬭	⬭	⬭	
Depression Medical History	⬭	⬭	⬭	
Eating Disorder Medical History	⬭	⬭	⬭	
Mood Swings/Bipolar Medical History	⬭	⬭	⬭	
Panic Attack Medical History	⬭	⬭	⬭	

Hematologic History	Self	Family	None	Comments
Anemia Medical History	⬭	⬭	⬭	
Bleeding Disorder Medical History	⬭	⬭	⬭	
Clotting Disorder Medical History	⬭	⬭	⬭	

Immunologic System History	Self	Family	None	Comments
HIV Medical History	⬭	⬭	⬭	

Oncologic History	Self	Family	None	Comments
Breast Cancer Medical History	⬭	⬭	⬭	
Skin Cancer Medical History	⬭	⬭	⬭	

Health History III
Previous Surgeries/Procedures/Hospitalizations

Type	Description	Date	Hospital/Facility	Comments
Procedure Surgery Illness Other				
Procedure Surgery Illness Other				
Procedure Surgery Illness Other				

⬭ **No Surgeries/Procedures/Hospitalizations**

Medical Devices	⬭	Pacemaker	Other	⬭	________________

Integumentary History

Does Patient Have:	Yes	No	Comments
History of Frequent Infections or Boils	⬭	⬭	
History of Large Scars of Keloids	⬭	⬭	

Allergy Profile

Allergy Type	Yes	No	Medication Name:	Reaction/Comments:
Medication Allergy	⬭	⬭		
Food Allergy	⬭	⬭		
Skin Allergy	⬭	⬭		

Medication Profile

PLEASE LIST ALL MEDICATIONS YOU ARE NOW TAKING OR HAVE TAKEN, INCLUDING BIRTH CONTROL, DIURETICS, BLOOD PRESSURE OR HEART MEDICATIONS, TRANQUILIZERS, HORMONES, BLOOD THINNERS, ASPIRIN, ETC

	Medication Name:	Dose:
Current Medications	⬭ NONE	
	1)	
	2)	
	3)	
	4)	
	5)	

Anesthesia/Transfusion History	Yes	No	Unknown	Type of Reaction
Prior Anesthesia Reaction	⬭	⬭	⬭	
Prior Transfusion Reaction	⬭	⬭	⬭	
Family Hist of Malignant Hyperthermia	⬭	⬭	⬭	

Other Significant Medical History

Description	Date	Comments

Nutrition

	Yes	No	Comments
Weight Gain Amount	⬭	⬭	lbs.
Weight Loss Amount	⬭	⬭	lbs.

Perception of Body Size	⬭	Just Right	⬭	Too Thin
	⬭	Too fat	⬭	Other:

Activity/Exercise

Exercise Type		Exercise Frequency		Exercise Duration per Session			
⬭	Aerobics	⬭	Daily	⬭	20-30 minutes		
⬭	Bicycling	⬭	4-6x/wk	⬭	30-60 minutes		
⬭	Jogging/Running	⬭	2-3x/wk	⬭	60-90 minutes		
⬭	Organized Team Sports	⬭	1x/wk	⬭	90-120 minutes		
⬭	Swimming	⬭	Other	⬭	Other:		
⬭	Walking						
⬭	Weight Training						
⬭	Yoga						
⬭	Other						

Social Habits

Social Habits			Type	Frequency	Amount	Last Use	Comments
Alcohol Use	⬭	None	Beer				
	⬭	Current	Liquor				
	⬭	Past	Wine				
	⬭	Other	Other				
Tobacco Use	⬭	None	Chewing Tobacco				
	⬭	Current	Cigarettes				
	⬭	Past	Cigars				
	⬭	Other	Pipe				
			Other				
Recreational Drug Use	⬭	None					
	⬭	Current					
	⬭	Past					
	⬭	Other					