neighborcare health

Adult Health History

Appointment Date: _______________

Name:		Date of Birth:	Born: ☐ Male ☐ Female

This information is very important to your health. Correct spelling is not important. If you need more space, please use the back of form.

Do you have any medication allergies? ☐Y ☐N

Allergies to: ☐ Bee or Wasp Sting ☐ Nuts ☐ Eggs ☐ Latex

LIST EVERY ONGOING MEDICAL & MENTAL ILLNESS	Age at Onset

SURGERIES, HOSPITALIZATIONS, & BROKEN BONES Surgeon/ Location	YEAR

MEDICATION NAMES, DOSES, & STRENGTHS
Include non-prescription drugs, vitamins, herbs/supplements

If you require additional space, please use the back of this form.

Name of previous providers, other current providers, clinic name and address

PERSONAL HISTORY

Ever had chickenpox? ☐Y ☐N

Last tetanus shot: Hepatitis A shot:

Last flu shot: Hepatitis B shot:

Last Pneumovax:

Tobacco use: ☐Never ☐Former ☐Current # packs/day____

Years as smoker____

Alcohol use: ☐Y ☐N If yes, # of drinks/week_____

☐ Married ☐ Single ☐ Divorced ☐ Widowed Year:

ADDITIONAL HISTORY

Do you identify yourself as: ☐ Male ☐Female ☐ Transgender

Do you have sex with: ☐ Men ☐ Women ☐ Both ☐Prefer not to answer

Are there any aspects about your sexuality or sexual health that you would like to discuss? ☐Y ☐N

Have you experienced physical/verbal abuse? ☐Y ☐N

Have you experienced possible HIV exposure? ☐Y ☐N

Use of other drugs (marijuana, cocaine, heroin, etc)? ☐Y ☐N

If yes, what drug?__________________

IF APPLICABLE (dates or year)

Last pap & results:

Last mammogram & results:

Periods regular? ☐ Y ☐ N Total # of pregnancies:

Birth control (if any): Total # of live births:

FAMILY HISTORY (Biologic)

FAMILY HISTORY (Biologic)	Self	Father	Mother	Grand-parent	Sibling
Heart Trouble / Heart Attack	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Cancer(s): Breast	☐	☐	☐	☐	☐
Cervical	☐	☐	☐	☐	☐
Colon	☐	☐	☐	☐	☐
Ovarian	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Alcohol / Drug Addiction	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Blood: Bleeding, Clotting	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐
High Cholesterol (Elevated Lipids)	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

[Patient Label Here]

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