DAN R. BAKER, MD

Adult Health History

(16 years and older)

Name: _____Date of Birth: _____

Check all items that apply to you and fill in blanks as needed. Complete all sections.

Past Medical History: (Please include dates) o N/A

- o Acne
- o ADD
  - o ADHD
- o Allergies(other than drug)_____
- o Anemia
  - o Other blood problems
- o Anesthesia complications
- o Arthritis, rheumatoid
  - o Osteoarthritis
- o Asthma
- o Cancer/Tumor, explain:_____
- o COPD
  - o Emphysema
  - o Other lung disease:_____
- o Depression
  - o Anxiety
  - o Suicide attempts
- o Diabetes, type 1
  - o Type 2, how long:_____
- o Drug abuse
  - o Alcohol abuse
- o Epilepsy (seizures)
- o Glaucoma
  - o Cataracts, L or R eye(s): _____
- o Gout
- o Headaches, type:_____
- o Hearing loss
  - o Deafness
- o Heart disease
  - o Heart disease
- o Hepatitis, A___ or B_____ or C____
- o High cholesterol
- o HIV or AIDS
- o Hypertension (high blood pressure)
- o Hypothyroid (low)
  - o Hyperthyroid (high)
- o Irritable Bowel Syndrome
  - o Colon disease
- o Kidney disease
  - o Kidney stone
- o Pap smear, Abnormal
- o Post menopausal, year of last period_____
- o Psychiatric treatment, in-patient or out-patient: _____
- o Reflux (GERD)
  - o Ulcer disease
- o Sexually transmitted disease (STD)_____
- o Skin disease
  - o Eczema
  - o Psoriasis
- o Stroke
- o Tuberculosis (TB), last chest x-ray_____
- o Other:

  _____

  _____

Females only> Number of : Pregnancies _____ Live Births _____ Miscarriages_____ Abortions____
Age at first period _____years old, Birth control method_____

Past Surgical & Hospitalization History: (Please include dates) o N/A

- o Angioplasty_____
- o Appendectomy _____
- o Back, procedure: _____
- o Blood transfusion, year _____
- o Breast, R or L, procedure_____
- o Cervical freezing _____
- o LEEP_____
- o Fracture _____
- o Gallbladder _____
- o Hernia, R or L, type _____
- o Hysterectomy (uterus)_____
  - o Ovaries removed also
- o Knee, R or L, procedure _____
- o Tonsillectomy _____
- o Tubal ligation (tubes tied) _____
- o Vasectomy _____
- o Other _____
- o Other _____

Procedures > Date of last: EKG _____ Colonoscopy _____ Eye exam _____ Stress test _____
Females only > Date of last: Pap Smear_____ Mammogram_____ Bone density_____
Males only > Date of last: Physical exam_____ Prostate exam_____ PSA_____

Current specialists: _____

Previous physicians: _____

Patient Name: _____

Drug Allergies: o No Known Drug Allergies

Name of Drug	Reaction

Current Medications: (prescriptions, birth control pills, over-the-counter, herbs, vitamins):

Medication	Strength/Dose	Frequency	Medication	Strength/Dose	Frequency

Immunizations: o Tetanus Booster _____ o Flu Vaccine _____ o Other _____

(Date received) o Pneumonia _____ o Hepatitis B _____ o TB skin test _____

Social History:

Marital Status: o Married o Divorced o Single o Separated o Widowed

Your Occupation: _____

Please check appropriate spots for each of the following items:

Tobacco use: o No o Yes (o Cigarettes o Chew/snuff , ? per day_____; how long___) o Quit, when_____

Alcohol use: o No o Yes (Quantity: number of drinks or bottles of beer per week_____)

Caffeine: o No o Yes (Quantity: number of cups/glasses/cans per day of coffee, tea or soda _____)

Recreational drugs: o No o Yes (what drugs do you use_____)

Sexually Active: o No o Yes

Seat Belt Use: o No o Yes

Family History:

	Living		Deceased	
	Age	Health Status or Illnesses	Age	Cause of death & Illnesses
Father				
Mother				
Father's father				
Father's mother				
Mother's father				
Mother's mother				
Brothers				
Sisters				
Children				

o Adopted – Family history unknown

Patient Signature: _____Date: _____/_____/_____

Provider Reviewed: _____Date: _____/_____/_____