Adult Health History Form

WAIKIKI HEALTH
MEDICAL & DENTAL · BEHAVIORAL HEALTH · SOCIAL SERVICES

Date: _____

Last Name:	First Name:	M.I.:

Are you currently taking any medication? (Prescription) ☐ YES ☐ NO
If yes, list: _____

Are you taking any over-the-counter, herbs, and vitamin/mineral/dietary supplements? ☐ YES ☐ NO
If yes, list: _____

Are you allergic to anything? ☐ YES ☐ NO If yes, to what? _____
Type of allergic reaction: _____

Have you been to a doctor in the last 12 months? ☐ YES ☐ NO

Have you ever been hospitalized? ☐ YES ☐ NO
If yes, when, where and why? _____

Are you pregnant? ☐ YES ☐ NO Previous pregnancy? ☐ YES ☐ NO # of children: _____

Do you utilize tobacco products? ☐ YES ☐ NO Type: _____ # of packs/day: _____

Do you drink alcohol? ☐ YES ☐ NO # of drinks/day: _____

Have you or anyone in your family had any of the following? (Enter 'YES' to self and/or family relationship)

Medical Condition	Self	Family (specify)	Medical Condition	Self	Family (specify)
Abnormal heart beat			Heart murmur		
AIDS/HIV			Hepatitis/Jaundice		
Anemia or blood disease			High blood pressure		
Arthritis			Indigestion		
Asthma			Kidney disease		
Behavioral health issues			Kidney stones		
Chest pains			Pain upon urination		
Chronic back pain			Pneumonia		
Chronic skin disease			Recent weight changes		
Complete or near stroke			Rheumatic heart disease		
Constipation			Serious injury		
Depressed, nervous or worried			Sexual problems		
Diabetes			Sexually transmitted infection		
Diarrhea			Swollen joints		
Drug abuse/addiction			T.B.		
Epilepsy/seizures			Thyroid problems		
Excessive tiredness			Tumors or cancer		
Frequent headaches			Ulcers		
Gallbladder disease			Unusual bleeding		
Hearing loss			Urinary track infection		
Heart attack			Vision loss		

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Do you have other significant medical information? ☐ YES ☐ NO
If yes, explain:

Social History Questions
Are there any changes to your family or social situation? ☐ YES ☐ NO If yes, explain: _____
Are you a caregiver? ☐ YES ☐ NO
Are you passively exposed to smoke? ☐ YES ☐ NO
Are there any smokers in your house? ☐ YES ☐ NO
Do you have an advanced directive? ☐ YES ☐ NO
Is a blood transfusion acceptable in an emergency? ☐ YES ☐ NO
Are you able to care for yourself? ☐ YES ☐ NO
Are you blind? ☐ YES ☐ NO Do you have difficulty seeing? ☐ YES ☐ NO If yes, explain: _____
Are you deaf? ☐ YES ☐ NO Do you have difficulty hearing? ☐ YES ☐ NO If yes, explain: _____
Do you have difficulty concentrating, remembering, or making decisions? ☐ YES ☐ NO
Do you have difficulty walking or climbing stairs? ☐ YES ☐ NO
Do you have difficulty dressing or bathing? ☐ YES ☐ NO
Do you have difficulty doing errands alone? ☐ YES ☐ NO
Are you able to walk? ☐ YES ☐ NO
Do you have transportation difficulties? ☐ YES ☐ NO