

ADOLESCENT/ADULT HEALTH HISTORY

Date _____

Name _____

- What is the reason for your visit today? bet blood test
- Is there anything about you and your health that we need to know? no
- List medicine, drugs, or food you are allergic to: none
- List any medicines or drugs you take: _____

5. Have YOU or anyone in your family had any of the following: (circle)

heart disease
high blood pressure
stroke

diabetes/sugar
blood problem or disease
cancer

tuberculosis
birth defects
mental retardation

nerve or mental problems
asthma
died before age 50
other "family" disease

- Have you ever been in the hospital? yes Why? childbirth, tubal
- Have you ever had surgery? yes Why? tubal
- Have you ever had a serious accident? no
- Have you had serious or recent problems with:

ears or throat
allergies
lung infections

NO YES
NO YES
NO YES

cough
thyroid
skin problems

NO YES
NO YES
NO YES

kidneys
weight loss
ulcers

NO YES
NO YES
NO YES

gallbladder
liver
depression
headaches

NO YES
NO YES
NO YES
NO YES

- Have you ever had a seizure, convulsion, or "falling out" spell? NO YES
- Have you ever had a blood clot in your lungs, legs or anywhere? NO YES
- Have you ever smoked cigarettes or used smokeless tobacco? NO YES
If yes, are you an Ex-smoker Smoking now? Do you smoke (less) (more) than a pack a day?
How much smokeless tobacco do you use a day? _____
- How often do you drink beer, wine, wine coolers, or liquor?
Never Rarely 1-2 times a week 3-4 times a week 5 or more times a week
If you drink beer, wine, wine coolers, or liquor, do you have:
(less) (more) than 5 drinks a day?
- Have you ever used marijuana, cocaine, crack or other drugs? NO YES
- Have you ever used I.V. drugs? NO YES
- Have you ever had a blood transfusion? NO YES
- Do you have any tattoos? NO YES
- Have you ever been treated for a venereal disease? NO YES
- Have you had more than one sex partner in the past 5 years? NO YES
- Have you ever had sex with a member of your own sex? NO YES
- Have you had or been around anyone with hepatitis? NO YES
- Did your sex partner(s) answer Yes to any of the questions 14-22? NO YES

FOR FEMALES ONLY

- How old were you when you started your periods? 12 Date of your last period? 1998
How often do you have your periods? _____ Are they regular? _____
How many days do they last? _____
Do you have: (circle) bad cramps bleeding or spotting between periods unusual discharge
- Do you have any problems with your breasts (lumps, discharge, or other)? NO YES
Do you check them regularly? YES NO
- How many times have you ever been pregnant? 1 How many children are living? 2
Have you ever had any children born dead; any stillbirths, miscarriages, or abortions? NO YES
Were any of your children premature? NO YES
How old were you when your first child was born? _____
- Have you ever used: (circle NO/YES) birth control pills? NO YES, condoms? YES IUD? NO YES, diaphragm? NO YES
- Did you have problems with any of these methods? NO YES
- Have you ever had an abnormal PAP smear? NO YES