

AUM NURSING CARE CENTER
ADOLESCENT/ADULT HEALTH HISTORY

Date 01/05/2018

Name Mital Kumar N Patel

1. What is the reason for your visit today? _____
2. Is there anything about you and your health that we need to know? _____
- *3. List medicine, drugs, or food you are allergic to: N/A
- *4. List any medicines or drugs you take: N/A
5. Have YOU or anyone in your family had any of the following: (circle)

heart disease	diabetes/sugar	tuberculosis	nerve or mental problems
high blood pressure	blood problem or disease	birth defects	asthma
stroke	cancer	mental retardation	died before age 50
			other "family" disease

6. Have you ever been in the hospital? _____ Why? _____
7. Have you ever had surgery? _____ Why? _____
8. Have you ever had a serious accident? _____
9. Have you had serious or recent problems with:

ears or throat	NO YES	cough	NO YES	kidneys	NO YES	gallbladder	NO YES
allergies	NO YES	thyroid	NO YES	weight loss	NO YES	liver	NO YES
lung infections	NO YES	skin problems	NO YES	ulcers	NO YES	depression	NO YES
						headaches	NO YES

10. Have you ever had a seizure, convulsion, or "falling out" spell? NO YES
11. Have you ever had a blood clot in your lungs, legs or anywhere? NO YES
- *12. 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? _____
- *13. 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?

- *14. Have you ever used marijuana, cocaine, crack or other drugs? ☒ NO YES
- *15. Have you ever used I.V. drugs? ☒ NO YES
16. Have you ever had a blood transfusion? ☒ NO YES
17. Do you have any tattoos? ☒ NO YES
18. Have you ever been treated for a venereal disease? ☒ NO YES
19. Have you had more than one sex partner in the past 5 years? ☒ NO YES
20. Have you ever had sex with a member of your own sex? ☒ NO YES
21. Have you had or been around anyone with hepatitis? ☒ NO YES
22. Would your sex partner(s) answer Yes to any of the questions 14-22? ☒ NO YES

FOR FEMALES ONLY

- A. How old were you when you started your periods? _____ Date of your last period? _____
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
- B. Do you have any problems with your breasts (lumps, discharge, or other)? NO YES
Do you check them regularly? YES NO
- *C. How many times have you ever been pregnant? _____ How many children are living? _____
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? _____
- D. Have you ever used: (circle NO/YES) birth control pills? NO YES; foam? NO YES; condoms? NO YES; IUD? NO YES;
diaphragm? NO YES
- E. Did you have problems with any of these methods? NO YES
- F. Have you ever had an abnormal PAP smear? NO YES