

ADOLESCENT/ADULT HEALTH HISTORY

Date 03-22-2016

Name Jennifer Peacock

- What is the reason for your visit today? Random more frequent dirty spells
- Is there anything about you and your health that we need to know? No
- List medicine, drugs, or food you are allergic to: Allergic to latex/Lactose intolerant/Can't have lorazepam
- List any medicines or drugs you take: none
- 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

Dementia runs after stroke runs in the family but occurs after age 60

- Have you ever been in the hospital? yes Why? Busted my head open when I was little
- Have you ever had surgery? no Why?
- Have you ever had a serious accident? no
- Have you had serious or recent problems with:

ears or throat NO YES
allergies NO YES
lung infections NO YES

cough NO YES
thyroid NO YES
skin problems NO YES

kidneys NO YES
weight loss NO YES
ulcers NO YES

gallbladder NO YES
liver NO YES
depression NO YES
headaches 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
- Would 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? 14 Date of your last period? Today
How often do you have your periods? Every month Are they regular? yes - some irregularity with diet change
How many days do they last? 5 days
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? n/a How many children are living? n/a
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? n/a
- Have you ever used: (circle NO/YES) birth control pills? NO YES; foam? NO YES; condoms? NO 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