



PATIENT ADULT HEALTH HISTORY

Welcome to Dallas Family Practice! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held **strictly confidential** and is released only with your written permission. **Psychiatric, Drug abuse, and HIV information require specific record release signatures.**

Last Name:	First:	Birthdate:	Sex:	Doctor Notes <i>please do not write in this area</i>		
Presenting Problem (Reason for this Visit):						
Have you or any blood relative had:						
	Yes	No	Who		Year	
Allergies, asthma, hay fever						
Anemia						
Alcoholism						
Arthritis						
Bleeding problems						
Birth defects						
Cancer						
Emphysema /COPD						
Epilepsy or seizures						
Gallbladder problems						
Glaucoma/Blindness						
Heart Trouble/Chest Pain						
Mental illness/Mood Disorder						
Migraine headaches						
Osteoporosis						
Rheumatic fever						
Stroke/Seizure						
Suicide/Attempts/Thoughts						
Thyroid disease/goiter						
Tuberculosis						
Ulcers/Frequent Heartburn						
Diabetes						
Have you ever been turned down for military, job, insurance?					Yes	No
Names of Other Present DRs	Last Visit	Immunizations	Year			
		Tetanus				
		Pneumovax				
		Flu Shot				
		Last TB Test (+) (-)				
ALLERGIES: Please list any drugs, foods, stings, x-ray contrast, etc. and reactions: NONE						

Provider Initials _____

PATIENT HEALTH HISTORY (cont'd.)

Patient Name: _____

PERSONAL HABITS/RISK FACTORS			Doctor Notes <i>please do no write in this area</i>
	Yes	No	Answers
Do you smoke or chew tobacco?			No. packs/day:
Have you ever smoked in the past?			
Any tattoos/non-ear piercings?			
Any Military service/overseas duty?			
Do you eat snacks regularly?			
Do you have an eating disorder?			
Any diet preferences/restrictions?			
Type			
DIETARY HABITS			Frequency or No.:
\checkmark Low fat			
No. servings/day vegetables/fruits			
No. servings/day grains			
No. times/week you eat red meat			
No. servings/day dairy			
No. caffeine drinks/day			
Ave. alcoholic drinks/week			
No. times "drunk"/year			
Ever been told you drink too much?			
Ever had a drug problem?			
Every used intravenous drugs?			Date last used:
Do you ever <i>not</i> use seat belts?			
No. hours sleep/day			
Highest grade level achieved			
Do you snore?			
Do you exercise regularly?			
What exercise do you do?			
How often/week?			Duration:
What do you do to relieve stress?			
Do you ever get "blue" or down?			
Any hobbies?			
Occupation:			
Do you hate your job?			
Is your job a risk to your health?			
If yes (in any way), please explain:			
SOCIAL HISTORY		Do you have children? If yes, please list No. & age(s)	
Are you: Married		Have you learned CPR?	
Divorced Single			
Widowed Living with "signif. other"			
SEXUAL HISTORY		Sexual partners in past year:	
Are you sexually active?	Yes	No	No. men
Is sex unsatisfactory in any way?			No. women
History of Chlamydia?			No. unprotected
Gonorrhea?			AIDS, cont'd
Venereal warts?			Would you like to have a test?
Are you concerned about AIDS?			Yes No

*If there are any special concerns you would like to discuss with the doctor, **please continue on the reverse of this sheet.** Thank you for providing us with this important information.*

Patient Initials: _____ Reviewing Provider Initials: _____ Date: _____