ADULT PATIENT HISTORY
Kathleen Knapp, DO

Name _____ **Date** _____ **Sex**: ☐ M ☐ F **Birthdate**: _____

MEDICATIONS (Including over-the-counter and herbal supplements)

_____

_____

_____

PREVIOUS HOSPITALIZATIONS/SURGERIES
(date, reason, hospital/physician)

_____

_____

_____

SOCIAL HISTORY:
Currently live at : _____ with _____
Marital status: _____
Last Grade Completed in school _____
Where did you grow up? _____
Ever live outside USA? ☐ Y ☐ N if yes, where _____
Tobacco Use (Smoke or Chew): ☐ Y ☐ N if yes, what _____
How much?_____ per day x _____ years
If quit, when? _____ previous use _____ per day x years

Alcohol Use: ☐ Y ☐ N if yes, what _____
How much?_____ per day x _____ years
If quit, when? _____ previous use _____ per day x years

Drug Use: ☐ Y ☐ N if yes, what _____
How much?_____ per day x _____ years
If quit, when? _____previous use _____ per day x years

Caffeine: ☐ Y ☐ N if yes, source _____amount per day _____

Exercise:☐ Y ☐ N if yes, type _____
How Often: _____

Occupation: _____
Exposure to chemicals or blood/body fluids at work? ☐ Y ☐ N

SAFETY:
Do you use safety belts? ☐ Y ☐ N
Do you have working smoke and carbon monoxide detectors?
☐ Y ☐ N
Do you feel safe at home? ☐ Y ☐ N
Has anyone ever
Hit you ☐ Y ☐ N
Threatened you ☐ Y ☐ N
Forced Sex on you ☐ Y ☐ N

ALLERGIES:

_____

_____

_____

Latex/tape allergy ☐ Y ☐ N

PERSONAL/FAMILY HISTORY

	Self	Mother	Father	Brother/Sister	Grandparents
Diabetes					
Cancer					
Heart Disease					
Stroke					
High Blood Pressure					
Seizures					
Glaucoma					
Thyroid Disease					
Kidney Disease					
Mental Health					
Other					

INDICATE DATE OF YOUR LAST:

Tetanus Shot	
Prevnar Vaccine	
Pneumovax Vaccine	
Flu Shot	
MMR Vaccine	
Hepatitis Vaccine	
Colonoscopy	
Eye Exam	
Dental Exam	
TB Test	
PSA Test (Men)	
PAP (Women)	
Mammogram	
Bone Density	
Shingles Vaccine	

Please give the following information about your family

Relationship	Age if alive	Age at death	State of health or cause of death
Father			
Mother			
Brother(s)			
Sister(s)			
Spouse			
Children			

MEDICAL HISTORY
(Check any past/current problems)

GENERAL:
☐fever ☐chills ☐sweats ☐fatigue
☐sleep problems ☐headaches ☐dizziness
☐weakness ☐loss of appetite
☐weight loss/gain ☐eating problems

ALLERGIC/IMMUNOLOGIC:
☐respiratory distress ☐hives ☐itching
☐difficulty swallowing ☐swelling ☐hay fever

EYES:
☐Glasses/contacts ☐drainage ☐redness ☐pain
☐blurring ☐double vision ☐itching

EARS, NOSE, THROAT, MOUTH:
☐pain/pressure (areas): _____
☐congestion/drainage (areas): _____
☐sneezing ☐decreased hearing
☐bad breath ☐frequent nose bleeds
☐problem with teeth/gums ☐ hoarseness

RESPIRATORY:
☐shortness of breath ☐cough
☐wheezing ☐blood in sputum
☐congestion/heaviness in chest
☐asthma ☐ positive TB test

CARDIOVASCULAR:
☐high blood pressure ☐easy fatigue ☐poor coloring
☐chest pain/pressure ☐irregular/rapid heartbeat
☐jaw/shoulder/arm pain ☐trouble breathing at night
☐excessive sweating ☐varicose veins/phlebitis
☐swelling/fluid retention ☐rheumatic fever

GASTROINTESTINAL:
☐stomach problems ☐pain ☐nausea ☐vomiting
☐indigestion/heartburn ☐gas ☐diarrhea ☐constipation
☐blood in stools ☐blood in vomitus
☐hemorrhoids ☐rectal pain ☐ hepatitis
☐change in bowel habits ☐gall bladder disease

GENITOURINARY:
☐kidney/bladder problems ☐frequency
☐burning/painful urination ☐night urination
☐blood in urine ☐difficulty starting to urinate

FEMALE:
☐genital sores ☐vaginal discharge ☐burning
☐pelvic pain ☐itching ☐bleeding
☐sexually transmitted disease
☐menstrual difficulties
☐date of last menstrual period _____
☐methods of contraception_____
☐ # pregnancies,
live births _____, miscarriages/abortions _____
☐ lumps in breasts ☐discharge from nipple

MALE:
☐penile discharge ☐sores/warts
☐pain in testicles ☐hernia ☐sexual difficulties
☐sexually transmitted disease

MUSCULOSKELETAL:
☐body aches ☐stiffness (areas) _____
☐swelling ☐joint pain (areas) _____
☐warmth ☐arthritis ☐gout

SKIN:
☐wounds (area) _____
☐sores (area) _____
☐dryness ☐itching ☐rashes
☐discoloration ☐lightening ☐easily bruises

NEUROLOGICAL:
☐tingling (area) _____
☐numbness ☐paralysis
☐convulsions/seizures
☐ Headaches ☐ Dizziness

PSYCHIATRIC:
☐stress ☐depression ☐anxiety ☐nervousness
☐unable to sleep ☐nightmares ☐memory loss

ENDOCRINE:
☐thyroid trouble ☐heat or cold intolerance
☐excessive sweating ☐thirst ☐hunger ☐diabetes

HEMATOLOGIC/LYMPHATIC:
☐swollen glands ☐anemia
☐tenderness of glands

Signature :_____ _____ Relationship _____ Date:_____

_____

_____

_____

_____

Physician: _____ Date: _____