

**North Scottsdale Internal Medicine**  
**Adult Health History Form**

Name: \_\_\_\_\_

Reasons for today's visit: #1 \_\_\_\_\_ #2 \_\_\_\_\_

**Medical History:** Please check if you or your family member has been diagnosed with these conditions by a doctor

( this section is not for symptoms or concerns)	YOURSELF	Mother	Father	Sister	Sister	Brother	Brother	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Living (L) or Deceased (D)	n/a										
Healthy / no problems											
Allergic Rhinitis – Seasonal Allergies											
Anemia											
Asthma											
Blood clot - DVT											
Blood clot - PE - Lung											
Cancer of Breast (if family history - age at diagnosis)											
Cancer of Cervix (if family history - age at diagnosis)											
Cancer of Ovaries											
Cancer of Prostate (if family history - age at diagnosis)											
Cancer of Colon (if family history - age at diagnosis)											
Cancer of Skin - specific type ->											
COPD / emphysema											
Diabetes											
Diverticulitis											
Diverticulosis											
Heart Attack (Coronary Artery Disease) (age diagnosis)											
Heart Burn / GERD:											
High Blood Pressure ( Hypertension )											
High Cholesterol ( Hyperlipidemia)											
High Sugar (Hyperglycemia)											
Hypothyroidism											
Kidney Disease (Renal Insufficiency)											
Osteoarthritis											
Osteopenia / Osteoporosis (circle one)											
Polyps of Colon											
Rheumatoid Arthritis											
Stroke / CVA (if family history - age at diagnosis)											
TIA											
OTHER:											
OTHER :											
OTHER :											

**Health Maintenance Screening Tests** – please indicate the month/year if you have had the following:

**COLONOSCOPY:**  Yes  No -> Date \_\_\_\_\_ Abnormal?  Yes  No → any polyps  Yes  No

**CHOLESTEROL:**  Yes  No -> Date \_\_\_\_\_ Abnormal?  Yes  No

**WOMEN:**

Mammogram  Yes  No -> Date \_\_\_\_\_ Abnormal?  Yes  No

Pap smear  Yes  No -> Date \_\_\_\_\_ Abnormal?  Yes  No

DEXA / Bone Density  Yes  No -> Date \_\_\_\_\_ Abnormal?  Yes  No →  Osteoporosis  Osteopenia

How many times have you been pregnant? \_\_\_\_\_ Abortions \_\_\_\_\_ Miscarriages \_\_\_\_\_ Living children \_\_\_\_\_

**MEN:** PSA (prostate)  Yes  No -> Date \_\_\_\_\_ Abnormal?  Yes  No

Abdominal Aneurysm U/S  Yes  No -> Date \_\_\_\_\_ Abnormal?  Yes  No (Only certain men who have smoked)

**Surgical History:** Please list all prior operations (with dates). *\*Please include Cesarean sections as a surgery\**

Appendectomy / Appendix Removed \_\_\_\_\_  
Tonsillectomy / Tonsils Removed \_\_\_\_\_  
Cholecystectomy / Gallbladder Removed \_\_\_\_\_  
Hysterectomy / Cervix/Uterus removed \_\_\_\_\_  
BSO / Ovaries Removed 1 or 2 \_\_\_\_\_  
Others \_\_\_\_\_

**Have you ever been admitted to the Hospital** if so for what and when (yr) *\*exclude ER visits, delivers, or surgery\**

**Social History:**

**Tobacco Use**

Cigarettes  Never  Quit Date \_\_\_\_\_ Previous amounts - Packs/day \_\_\_\_\_ # of years \_\_\_\_\_  
 Current Smoker: Packs/day \_\_\_\_\_ # of years \_\_\_\_\_  
Other Tobacco:  Pipe  Cigar  Chew  
Are you interested in quitting?  Yes  No

**Alcohol Use**

Do you drink alcohol?  Yes  No - # of drinks/day \_\_\_\_\_  
Is your alcohol use a concern to you or others?  Yes  No

**Drug Use**

Do you use any recreational drugs?  Yes  No  
Have you ever used needles to inject drugs?  Yes  No

**Caffeine Intake**  None  Coffee/tea/soda \_\_\_\_\_ cups/daily

**Exercise**

Do you exercise regularly?  Yes  No  
What kind of exercise? \_\_\_\_\_ How long (minutes)? \_\_\_\_\_ How Often? \_\_\_\_\_  
If you do not exercise is there a reason why? \_\_\_\_\_

**Sexual Activity**

Sexually active:  Yes  No  Not Currently  
Birth Control Method: \_\_\_\_\_  
Have you ever had any sexually transmitted diseases (STDs)?  
 Yes  No If yes, \_\_\_\_\_  
Are you interested in being screened for sexually transmitted diseases?  
 Yes  No

**Socioeconomics:**

Occupation: \_\_\_\_\_ Employer : \_\_\_\_\_  
Marital Status: Single Partner/Married Other \_\_\_\_\_  
Spouse / partner's name: \_\_\_\_\_ Number of Children \_\_\_\_\_

**Review of Systems / Symptoms:** Please check any current symptoms you have.

**Constitutional**

\_\_\_\_ Chills  
\_\_\_\_ Night Sweats  
\_\_\_\_ Weight change  
\_\_\_\_ Fevers  
\_\_\_\_ Fatigue

**Neurology**

\_\_\_\_ Headaches  
\_\_\_\_ Memory Loss

**Psychology**

\_\_\_\_ Depression  
\_\_\_\_ Anxiety

