Penn Medicine

Patient Name: _____

DOB: _____

ADULT HEALTH ASSESSMENT SHEET

FAMILY HISTORY

Has anyone in your **IMMEDIATE** family had any of the following illnesses:

Illness	Which Family Member	Age When Diagnosed	Illness	Which Family Member	Age When Diagnosed
Cancer (describe type)			Bleeding Disorders		
High Blood Pressure			Diabetes		
Heart Disease			Asthma		
Strokes			Epilepsy		
Mental Disease			Genetic Disease		
Glaucoma			Arthritis		
Drug/Alcohol Addiction			Kidney Problems		
			Other		

SOCIAL HISTORY

How many people live with you now? _____

Present occupation _____

Previous occupations _____

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? _____

_____

Have you ever been exposed to any environmental hazards such as radiation, toxic waste, or lead paint? _____

_____

PERSONAL HABITS

Do you wear your seat belt?	No ☐	Yes ☐	
Do you wear a bike helmet?	No ☐	Yes ☐	N/A ☐
Do you use tobacco products?	No ☐	Yes ☐	If yes, what kind? _____ How much? _____
Do you drink alcohol?	No ☐	Yes ☐	If yes, how much per week? _____
coffee?	No ☐	Yes ☐	If yes, how many cups per day? _____
tea?	No ☐	Yes ☐	If yes, how many cups per day? _____
Do you follow a particular diet?	No ☐	Yes ☐	If yes, what type? _____
Do you exercise regularly?	No ☐	Yes ☐	If yes, what type? _____
Any recent travel outside U.S.?	No ☐	Yes ☐	
Do you have a gun in your house?	No ☐	Yes ☐	If yes, is it under lock and key? _____
Do you use drugs? (cocaine, crack, marijuana, amphetamines, etc)	No ☐	Yes ☐	
Do you have smoke detectors in your home?	No ☐	Yes ☐	

PLEASE TURN AND COMPLETE OTHER SIDE.

Patient Name: _____ DOB: _____

IMMUNIZATIONS

Have you had any of the following **IMMUNIZATIONS**:

Hepatitis B?	No ☐	Yes ☐	Approximate Date _____
Tetanus?	No ☐	Yes ☐	Approximate Date _____
Flu Shot?	No ☐	Yes ☐	Approximate Date _____
Pneumovax?	No ☐	Yes ☐	Approximate Date _____
Measles?	No ☐	Yes ☐	Approximate Date _____
Mumps?	No ☐	Yes ☐	Approximate Date _____
Rubella?	No ☐	Yes ☐	Approximate Date _____

HEALTH MAINTENANCE

When was your **LAST**: (give approximate date)

Pap Smear?	_____	Cholesterol Check?	_____
Breast Exam?	_____	Stool Check for Blood?	_____
Mammogram?	_____	Prostate Exam?	_____
Complete Physical?	_____	Colonoscopy Exam?	_____

Do you have a "living will" or advance directive?	No ☐	Yes ☐
Are you an organ donor?	No ☐	Yes ☐

Completed By: _____ Date: _____

Reviewed By: _____ Date: _____

Penn Medicine

PATIENT NAME:
DOB:

ADULT HEALTH ASSESSMENT SHEET

In order to help us deliver quality care, we would appreciate your responses to the personal history questions below. Please be assured that all responses are kept confidential. You should feel free to discuss any questions you have concerning these items with the doctor or nurse.

DO YOU HAVE ANY PARTICULAR HEALTH CONCERNS AT THIS TIME YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR OR NURSE ? _____

_____

_____

ALLERGIES

Do you have any allergies to medications, foods, or other substances? If yes, please list along with the reaction you have.

_____ _____

_____ _____

MEDICATIONS

Please list all **MEDICATIONS** including the **DOSES** that you are currently taking: (Prescription, Over the Counter, Vitamins, Herbs)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please check if you have any of these diseases or if you have any of these symptoms that reoccur frequently:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Chest Pain/ Tightness
- ☐ Heart Murmur
- ☐ Shortness of Breath
- ☐ Swollen Ankles
- ☐ Palpitations/Heart Pounding
- ☐ Lightheadedness
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Persistent Cough
- ☐ Hay Fever
- ☐ Sinus Problems
- ☐ Abdominal Discomfort
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Change in Bowel Habits
- ☐ Blood in Stool
- ☐ Hemorrhoids
- ☐ Ulcers
- ☐ Unexplained Weight Loss/ Gain
- ☐ Colitis
- ☐ Gall Bladder Disease
- ☐ Pancreatitis
- ☐ Liver Disease
- ☐ Hepatitis/Yellow Jaundice
- ☐ Thyroid Disease
- ☐ Head or Neck Radiation
- ☐ Headache
- ☐ Migraines
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Difficulty Urinating
- ☐ Frequent Urination
- ☐ Arthritis
- ☐ Low Back Problems
- ☐ Bone/Joint Problem
- ☐ Blood Transfusions
- ☐ Anemia
- ☐ Blood Disorders
- ☐ Lumps/Moles
- ☐ Skin Diseases
- ☐ Sexually Transmitted Diseases
- ☐ HIV/AIDS
- ☐ Anxiety
- ☐ Depression
- ☐ Sleeping Problems
- ☐ Alcohol Abuse
- ☐ Drug Abuse
- ☐ Gout
- ☐ Seizures
- ☐ Visual Problems
- ☐ Hearing Problems
- ☐ Measles
- ☐ Chicken Pox
- ☐ Mumps
- ☐ _____
- ☐ _____

PATIENT NAME: DOB:

Please list all **HOSPITALIZATIONS** and **OPERATIONS** you have had and give the approximate **DATE** of each:

_____ _____

_____ _____

_____ _____

For **WOMEN** Only:

Date of last menstrual cycle _____ Age of Onset of Periods?_____
Do you do self breast exams monthly? No ☐ Yes ☐
Any history of abnormal Pap Smears? No ☐ Yes ☐ If yes, explain _____
Any prolonged or abnormal bleeding? No ☐ Yes ☐
Any pelvic pain? No ☐ Yes ☐
Any abnormal discharge? No ☐ Yes ☐
Do you take a calcium supplement? No ☐ Yes ☐
Number of Pregnancies_____ Number of miscarriages or abortions _____

For **MEN** only:

Do you do self testicular exams? No ☐ Yes ☐
Have you had a prostate exam? No ☐ Yes ☐
Have you had a PSA (blood work to check your prostate)? No ☐ Yes ☐
Have you ever had an abnormal prostate exam or PSA? No ☐ Yes ☐ If yes, explain _____

_____

Do you have any problems with urination? No ☐ Yes ☐ If yes, explain_____

_____

SEXUAL HISTORY

Are you sexually active? No ☐ Yes ☐
Would you characterize your sexual preferences as:
☐ Heterosexual ☐ Homosexual ☐ Bisexual
Do you have multiple sexual partners? No ☐ Yes ☐
Do you use condoms? No ☐ Yes ☐
What method of contraception do you use?_____

FAMILY HISTORY

Is your mother alive? No ☐ Yes ☐ If not, age at death and cause of death _____
Is your Father alive? No ☐ Yes ☐ If not, age at death and cause of death _____
Number of siblings: Sisters _____ Brothers _____
Do any of your siblings have a serious illness?_____ If yes, explain _____

_____