PACIFIC GROVE
FAMILY MEDICINE

ADULT HEALTH HISTORY

Today's Date: ___________________

Name: _____________________________________ Date of Birth: ______________________

Email: ____

Pharmacy: ____

Please check if you have or have had any of the following:

☐ High Blood Pressure	☐ Pneumonia	☐ Colon Polyps
☐ Heart Attack	☐ Asthma	☐ Diverticulitis
☐ Heart Murmur	☐ Emphysema / COPD	☐ Hepatitis
☐ Heart Failure	☐ Gallstones	☐ Anemia
☐ Diabetes	☐ Stomach Ulcer	☐ Thyroid Disorder
☐ High Cholesterol	☐ Hiatal Hernia	☐ Kidney Stone
☐ Cancer: if yes; type ___________	☐ Stroke	☐ Convulsion
☐ Depression	☐ Anxiety	☐ Arthritis
☐ Convulsion	☐ Arthritis	☐ Sexually Transmitted Dz

Past Medical History (not listed above): ____

____

Medications: ____

____

Allergies (medications and reactions): ____

____

Food allergies and reaction: ____

____

List serious illnesses / injuries / surgeries and year (Not to include Normal Pregnancies and Deliveries)

Year Illness, Injury, Surgery

___________ ____

___________ ____

___________ ____

___________ ____

___________ ____

___________ ____

Obstetrical: # of pregnancies ______ # of abortion ______ # of miscarriages ______

# of living children ______ #C-section________ # vaginal deliveries_____

Immunizations: Tetanus ______ Pneumonia ______ Shingles ______

FAMILY MEDICAL HISTORY

	Mother	Father	Sibling	Grandparent	Aunt / Uncle	Child
High Blood Pressure						
Heart Attack						
High Cholesterol						
Diabetes						
Stroke						
Cancer (type)						
Tuberculosis						
Bleeding Disorder						
Alcoholism						

Mother living? ☐ Yes ☐ No Cause of death? _______________________________

Father living? ☐ Yes ☐ No Cause of death? _______________________________

Sexual Identity: ☐ Heterosexual ☐ G/L ☐ Bisexual ☐ Transgender

SOCIAL HISTORY

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Significant Other / Partner

Number of Children: _________ Sons: _________ Daughters: _________

Occupation: ____

Who lives with you? ____

Do you have a living will? ☐ Yes ☐ No

Health Care Power of Attorney? ☐ Yes ☐ No

HABITS

Have you ever smoked? ☐ Yes ☐ No

If yes; how many packs per day? _________ How many years? _________

Do you smoke now? ☐ Yes ☐ No; Quit _________ years ago

Any other tobacco use? __________________

Do you drink coffee / caffeinated drinks? ☐ Yes ☐ No

If yes; how many cups of coffee / caffeinated drinks per day? _________

Do you drink alcohol? ☐ Yes ☐ No

What type? (circle any that apply) beer wine liquor

How much? _______________ How often? ________________

Do you exercise? ☐ Yes ☐ No How often? _________ What type? ________

Do you follow a special diet? ☐ Yes ☐ No What type? _________

Do you wear seatbelts? ☐ Yes ☐ No

Do you self Exam? (breast or testicular) ☐ Yes ☐ No

Do you have a history of substance abuse? ☐ Yes ☐ No What type? ______________________

Time in sobriety / recovery? ______________________________

Do you have firearms in the house? ☐ Yes ☐ No

PATIENT HEALTH QUESTIONNAIRE

NAME: ____ **DATE:** ______________

Over the last 2 weeks, how often have you been
Bothered by any of the following problems?
(use ☑ to indicate your answer)

	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL,
Please refer to accompanying scoring card).

10. If you checked off *any problems,* how *difficult* Have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ______ Somewhat difficult ______ Very difficult ______ Extremely difficult ______