ACCESS WELLNESS GROUP
ADULT HEALTH HISTORY

Name: _____ SS#:_____

DOB:_____ Sex: _____

Physician: _____ Date of last physical exam: _____

MEDICATIONS
List all prescription and over-the-counter medicines, including vitamins and herbs, you are currently taking:

MEDICATION	DOSAGE	MEDICATION	DOSAGE

REVIEW OF SYSTEMS: Have you ever been treated for, or had any known indications of, the following problems in the Past, Now, or Never (please check one)? If Past or Now, please circle those problems that apply, and explain the nature of the problem, dates, and treatment.

Past	Now	Never	
❑	❑	❑	Problems with eyes, ears, nose and throat (including change in vision, appearance of eyes, hoarseness, trouble swallowing)?
❑	❑	❑	Dizziness, fainting, headaches, fatigue, seizures, head injuries?
❑	❑	❑	Chest pain, high blood pressure, heart attack, stroke, or other heart disorders, blood diseases, hardening of the arteries?
❑	❑	❑	Cough, shortness of breath, asthma, chronic obstructive pulmonary disease (COPD), emphysema or other respiratory problems?
❑	❑	❑	Ulcers or other stomach problems?
❑	❑	❑	Anemia, thyroid, liver, or jaundice problems?
❑	❑	❑	Diabetes or hypoglycemia?
❑	❑	❑	Disorder of muscles, bones, back, joints, or arthritis?
❑	❑	❑	Bowel or urinary problems?
❑	❑	❑	Genetic disorders or birth defects?
❑	❑	❑	Cancer, disorders of the skin, or tumors?
❑	❑	❑	Infectious diseases (tuberculosis, hepatitis, HIV/AIDS, herpes, syphilis, etc.)?
❑	❑	❑	Have you had a TB test? Result? Date:
❑	❑	❑	Spitting up blood or blood in stool or urine?
❑	❑	❑	Drenching night sweats?
❑	❑	❑	Do you drink alcohol or use non-prescription drugs/street drugs (frequency, amount, and duration of use)?
❑	❑	❑	DT's or blackouts?
❑	❑	❑	Do you use tobacco or nicotine replacement products? If yes, how much per day?
❑	❑	❑	Do you have sleep problems? Describe
❑	❑	❑	Do you use alcohol/drugs/medication to help you sleep?
❑	❑	❑	Major health problems, hospitalizations, surgeries, or visits to the emergency room not listed above?

❑	❑	❑	Are you required to be on a special diet? If yes, describe
❑	❑	❑	Do you diet, use diet pills, or follow an unusual diet?
❑	❑	❑	Have you gone more than a day without eating any food, except when ill?
❑	❑	❑	Change in appetite or weight in last six months? If change in weight, list amount
❑	❑	❑	Any allergies (plants, animals, insects, food, medications, etc.)?
❑	❑	❑	Problems with female or male organs?
❑	❑	❑	Sexually active?
❑	❑	❑	Have you ever been abused (physical, sexual)?

Do you have any history of head trauma. If so explain:_____

_____

How much caffeine do you drink daily (coffee, tea, cola, etc.)?_____

Date of last dental examination and dentist: _____

Current weight: _____ Current height: _____

Women only: Are you pregnant? ❑Yes ❑No Do you use birth control? ❑Yes ❑No Method? _____

Have members of your family had a history of:	Who		Who
Alcohol abuse		Drug abuse	
Depression		Psychiatric Hospitalization	
Anxiety Disorder		Suicide	
Other major medical illness (such as thyroid disease, diabetes, etc.)			

_____ _____ _____

Signature of person completing this form Date Relationship to client if other than self

THIS SECTION FOR OFFICE USE ONLY	
Staff Comments/Observations:	Medical Director Comments (if needed):
	❑ A physical exam is needed/indicated for appropriate mental health evaluation and treatment
	❑ A physical exam is not required for our mental health evaluation and treatment
_____ _____ Clinician's Signature/Title Date	_____ _____ Physician Signature/Title Date

Client was informed of need for physical examination on _____ by _____

Date Signature and title of clinician

Chronology of follow up with client (or legal guardian)