Arizona Institute
of Medicine & Pediatrics

ADULT CONFIDENTIAL PERSONAL HEALTH HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

Please answer the following questions completely and to the best of your ability. If you are not certain of the appropriate response to a question, please discuss it further with your physician. If the answer is "none", circle NONE.

PRIMARY CONCERNS FOR THIS OR FUTURE APPOINTMENTS:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

ALLERGIES/ MEDICATION REACTIONS: NONE

MEDICATION NAME	DESCRIBE REACTION

PAST MEDICAL HISTORY: NONE (CHECK ALL CONDITIONS OR SYMPTOMS YOU HAVE HAD DIAGNOSED OR TREATED)

CONDITION	ONGOING?		DATE BEGAN
❑ Allergies	❑ Yes	❑ No	_____
❑ Anemia	❑ Yes	❑ No	_____
❑ Angina	❑ Yes	❑ No	_____
❑ Anxiety	❑ Yes	❑ No	_____
❑ Arthritis, Osteo.	❑ Yes	❑ No	_____
❑ Arthritis, Rheumatoid	❑ Yes	❑ No	_____
❑ Asthma	❑ Yes	❑ No	_____
❑ Atrial Fibrillation	❑ Yes	❑ No	_____
❑ Bleeding Disorder	❑ Yes	❑ No	_____
❑ Blood Clots	❑ Yes	❑ No	_____
❑ Cancer: _____	❑ Yes	❑ No	_____
❑ Cataracts	❑ Yes	❑ No	_____
❑ Chronic Back Pain	❑ Yes	❑ No	_____
❑ Chronic Bronchitis	❑ Yes	❑ No	_____
❑ Chronic Diarrhea	❑ Yes	❑ No	_____
❑ Colon Polyps	❑ Yes	❑ No	_____
❑ Constipation	❑ Yes	❑ No	_____
❑ Crohn's Disease	❑ Yes	❑ No	_____
❑ Depression	❑ Yes	❑ No	_____
❑ Diabetes	❑ Yes	❑ No	_____
❑ Eating Disorder	❑ Yes	❑ No	_____
❑ Emphysema	❑ Yes	❑ No	_____
❑ Fibromyalgia	❑ Yes	❑ No	_____
❑ Gallstones	❑ Yes	❑ No	_____
❑ Goot	❑ Yes	❑ No	_____
❑ Headaches	❑ Yes	❑ No	_____
❑ Hearing Loss	❑ Yes	❑ No	_____
❑ Heart Attack	❑ Yes	❑ No	_____
❑ Heart Failure	❑ Yes	❑ No	_____
❑ Heartburn	❑ Yes	❑ No	_____
❑ Hemorrhoids	❑ Yes	❑ No	_____
❑ Hepatitis _____	❑ Yes	❑ No	_____

CONDITION	ONGOING?		DATE BEGAN
❑ High Cholesterol	❑ Yes	❑ No	_____
❑ HIV/AIDS	❑ Yes	❑ No	_____
❑ Hypertension	❑ Yes	❑ No	_____
❑ Kidney Failure	❑ Yes	❑ No	_____
❑ Kidney Stones	❑ Yes	❑ No	_____
❑ Lupus	❑ Yes	❑ No	_____
❑ Mental Illness	❑ Yes	❑ No	_____
❑ Ovary Problems	❑ Yes	❑ No	_____
❑ Pancreatitis	❑ Yes	❑ No	_____
❑ Pneumonia	❑ Yes	❑ No	_____
❑ Poor Circulation	❑ Yes	❑ No	_____
❑ Prostate Problems	❑ Yes	❑ No	_____
❑ Psoriasis	❑ Yes	❑ No	_____
❑ Rheumatic Fever	❑ Yes	❑ No	_____
❑ Seizures	❑ Yes	❑ No	_____
❑ Sexual Dysfunction	❑ Yes	❑ No	_____
❑ Shingles	❑ Yes	❑ No	_____
❑ Skin Lesions	❑ Yes	❑ No	_____
❑ Stomach Ulcers	❑ Yes	❑ No	_____
❑ Stroke	❑ Yes	❑ No	_____
❑ Testicular Problems	❑ Yes	❑ No	_____
❑ Thyroid Disease	❑ Yes	❑ No	_____
❑ Tuberculosis	❑ Yes	❑ No	_____
❑ Ulcerative Colitis	❑ Yes	❑ No	_____
❑ Valley Fever	❑ Yes	❑ No	_____
❑ Vision Problems	❑ Yes	❑ No	_____
❑ Other (list all):			

_____
_____
_____
_____
_____

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LIST ALL PREVIOUS SURGERIES AND HOSPITALIZATIONS: NONE

SURGERY/HOSPITALIZATION	PHYSICIAN/SURGEON	MONTH/YEAR

LIST CURRENT MEDICATIONS: NONE

*** Including over-the-counter medications, such as vitamins, pain relievers, laxatives, and naturopathic preparations such as herbs and teas.

MEDICATION NAME	STRENGTH OR DOSE	FREQUENCY

LIST ALL HEALTHCARE PROVIDERS WHO HAVE TAKEN CARE OF YOU IN THE LAST THREE (3) YEARS: NONE

PHYSICIAN NAME	SPECIALTY/YEAR	CITY/STATE	CONDITION TREATED

FAMILY HISTORY: NONE (LIST ALL CHRONIC MEDICAL CONDITIONS IN THE IMMEDIATE FAMILY)

Arthritis, Osteo _____
Arthritis, Rheumatoid _____
Asthma _____
Blood Clots _____
Cancer, Breast _____
Cancer, Colon _____
Cancer, Skin _____
Cystic Fibrosis _____
Depression _____
Diabetes _____
Heart Attack _____
Hypertension _____
High Cholesterol _____
Lupus _____
Stroke _____
Thyroid Problems _____
Other _____
Other _____

SOCIAL/DEVELOPMENT HISTORY:

Birthplace: _____
Marital Status: _____
Occupation: _____ Retired? _____
Years in Arizona: _____ Winter Visitor? _____
Hobbies: _____
Pets: _____

YEAR OF LAST INJECTION OR TEST:

_____ Bone Scan (Osteoporosis)
_____ Cardiac Catheterization
_____ Chest X-ray
_____ Cholesterol Test
_____ Colonoscopy
_____ EKG
_____ Flu Vaccine
_____ Hepatitis A Vaccine
_____ Hepatitis B Vaccine
_____ MMR Vaccine
_____ Pneumonia Vaccine
_____ PSA Test
_____ Pulmonary Function Test
_____ Sigmoidoscopy
_____ Stool for Occult Blood
_____ TB Skin Test
_____ Tetanus Vaccine
_____ Treadmill for Heart

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SYSTEM REVIEW: (CIRCLE ANY SYMPTOM YOU CURRENTLY HAVE, OR THAT HAS BEEN A RECURRING PROBLEM)

DO YOU WEAR ANY OF THE FOLLOWING?

❑ Dentures	❑ Hearing Aids	❑ Glasses	❑ Contact Lenses

GENERAL:

❑ Dizziness	❑ Fatigue	❑ Sleep Problems	❑ Other: _____
❑ Excess Thirst	❑ Fevers	❑ Weight Gain	❑ Other: _____
❑ Fainting	❑ Mood Swings	❑ Weight Loss	❑ Other: _____

SKIN INTEGUMENT:

❑ Bruising	❑ Hives	❑ Moles	❑ Rashes
❑ Eczema	❑ Itchiness	❑ Psoriasis	❑ Other: _____

HEAD AND NECK:

❑ Blurred Vision	❑ Eye Pain/Floaters	❑ Hearing Loss	❑ Neck Swelling
❑ Dental Pain	❑ Jaw Pain	❑ Hoarseness	❑ Nosebleeds
❑ Double Vision	❑ Hayfever	❑ Mouth Sores	❑ Sinus Infections
❑ Ear Ringing	❑ Headaches	❑ Neck Pain	❑ Sore Throats
❑ Eye Infections	❑ Head Injury	❑ Lymph Nodes	❑ Other: _____

GASTROINTESTINAL:

❑ Abdominal Pain	❑ Change in Bowels	❑ Heartburn	❑ Vomiting
❑ Black/Tarry Stool	❑ Constipation	❑ Loss of Appetite	❑ Other: _____
❑ Bloating/Gas	❑ Diarrhea	❑ Painful Swallowing	❑ Other: _____
❑ Blood in Stool	❑ Hard to Swallow	❑ Persistent Nausea	❑ Other: _____

PULMONARY:

❑ Blood in Sputum	❑ Shortness of Breath Lying Down
❑ Cough	❑ Shortness of Breath on Exertion
❑ Wheezing	❑ Shortness of Breath at Rest
❑ Other: _____	❑ Other:_____

CARDIAC/CIRCULATION:

❑ Angina	❑ Chest Tightness	❑ Murmur	❑ Varicose Veins
❑ Chest Pain	❑ Irregular Pulse	❑ Palpitations	❑ Other: _____
❑ Chest Pressure	❑ Leg Pain on Walking	❑ Swollen Ankles	❑ Other: _____

GENITOURINARY:

❑ Blood in Urine	❑ Sexual Dysfunction	❑ Decreased Urine Stream
❑ Increased Urine Frequency	❑ Decreased Urine Control	❑ Other: _____
❑ Genital Discharge	❑ Painful Urination	❑ Other: _____

NERVOUS SYSTEM:

❑ Anxiety/Nervousness	❑ Memory Loss	❑ Seizures
❑ Chronic Pain	❑ Mental Illness	❑ Ties
❑ Depression	❑ Numbness/Tingling	❑ Other: _____
❑ Knocked Unconscious	❑ Phobias	❑ Other: _____

MUSCULOSKELETALS:

❑ Joint Pain	❑ Joint Swelling	❑ Joint Deformity	❑ Other: _____
❑ Muscle Weakness	❑ Muscle Pain	❑ Muscle Wasting	❑ Other: _____

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HEALTH RISK ASSESSMENT:

CAFFEINE USE: NONE Indicate the amount of coffee and tea taken per day: _____
Indicate the amount of soft drinks taken per day: _____

ALCOHOL USE: NONE	NEVER	MONTHLY	2-4X PER MONTH	2-4X PER WEEK	DAILY
How often do you have 1 drink on an occasion?	❑	❑	❑	❑	❑
Do you have 6 or more drinks on an occasion?	❑	❑	❑	❑	❑
Anyone injured because of your drinking?	❑	❑	❑	❑	❑
Anyone suggest that you cut down drinking?	❑	❑	❑	❑	❑
□□□□often in the last year have you:					
Not been able to stop drinking, once started:	❑	❑	❑	❑	❑
Failed expectations because of your drinking:	❑	❑	❑	❑	❑
Needed a "first drink" in the morning:	❑	❑	❑	❑	❑
Felt guilt or remorse after drinking:	❑	❑	❑	❑	❑
Been unable to remember the night before:	❑	❑	❑	❑	❑

TOBACCO USE: NONE Have you smoked cigarettes? ❑ Yes ❑ No Began: ____ Packs/day: ____ Quit: ____
Have you used other tobacco products (cigars, snuff, chew)? ❑ Yes ❑ No
Have any of your roommates smoked cigars or cigarettes? ❑ Yes ❑ No

DRUG USE: NONE

Have you used IV drugs? ❑ Yes ❑ No		Are you still using IV drugs? ❑ Yes ❑ No	
Have you used marijuana? ❑ Yes ❑ No		Are you still using marijuana? ❑ Yes ❑ No	
Have you used cocaine? ❑ Yes ❑ No		Are you still using cocaine? ❑ Yes ❑ No	
Have you used crystal? ❑ Yes ❑ No		Are you still using crystal? ❑ Yes ❑ No	

HIV/AIDS RISK:
Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, what year(s)? _____
Have you used intravenous drugs within the last 10 years? ❑ Yes ❑ No
Have you engaged in unprotected sex within the last 10 years? ❑ Yes ❑ No
Have you had multiple sexual partners within the last 10 years? ❑ Yes ❑ No

OTHER HEALTH BEHAVIORS:

Do self-breast/testicular exams? ❑ Yes ❑ No		Exercise regularly? ❑ Yes ❑ No	
Wear seat belts regularly? ❑ Yes ❑ No		Limit cholesterol in your diet? ❑ Yes ❑ No	
Routinely wear sun protection? ❑ Yes ❑ No		Visit a dentist annually? ❑ Yes ❑ No	
Visit an optometrist annually? ❑ Yes ❑ No		Have a smoke detector in your home? ❑ Yes ❑ No	

GYNECOLOGIC HISTORY: *(FOR FEMALES ONLY)*

Age at onset of menses: _____years	Date of last menstrual period: _____
Length of montly cycle: _____ days	Cycle is/was: ❑ Regular ❑ Irregular
Length of menstruation: _____ days	Flow is/was: ❑ Light ❑ Moderate ❑ Heavy
Age at menopause: _____years	Menopause was: ❑ Natural ❑ Surgical
Number of: Pregnancies _____ Live Births _____	Miscarriages _____ Abortions _____
Date of last PAP smear: _____	Date of last mammogram: _____
Have you ever had an abnormal PAP smear? ❑ Yes ❑ No	If yes, when? _____
Have you ever had an abnormal mammogram? ❑ Yes ❑ No	If yes, when? _____

PSYCHOLOGIC HISTORY: Please indicate if you now have or in the past have ever experienced the following:

C= CURRENT P= PAST N= NONE

Depression: ____ Mania/ Psychosis ____ Sexual Abuse ____ Physical Abuse ____ Suicidal/ Homicidal Thoughts ____

I have answered all of the questions in this confidential questionnaire as honestly, accurately, and completely as I can.

_____ _____
PATIENT'S SIGNATURE DATE